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ABSTRACT

This Congressional report contains a state-by-state look at what is being done about teen pregnancy. Data are presented from a survey of state governors which examined the impact of current teen pregnancy policies and programs. Information regarding needs, services, special projects, and initiatives is included. Barriers to successful programs, as well as recommendations for improving current efforts are presented. The data are organized into four chapters: (1) National Perspectives on Adolescent Pregnancy and Parenting; (2) Barriers and Serving At-Risk, Pregnant, and Parenting Teens; (3) Federal Policies and Programs, and State Efforts; and (4) State Efforts to Serve At-Risk, Pregnant, and Parenting Teens. Findings are presented which illustrate the high costs of pregnancy to teens, their children, and the government, especially in terms of health care costs and support programs. States are unable to document extent of teen pregnancy, what benefits teens are receiving, who finishes school, effects of pregnancy; moreover fewer than one-half of the states can provide information on federal efforts. Significant barriers to improved services include overlooking prevention efforts, not taking a comprehensive approach to the issue, providing insufficient education for teens and communities, poor coordination, inadequate funding and insufficient data, and rarely making an effort to involve teen fathers. Two promising trends are reported: more states are focusing attention on teen pregnancy, and parental involvement is increasing. Appendices include the questionnaire submitted to the governors, references (including all documents submitted by states), federal program descriptions, and the 1985 Adolescent Family Life Grantees listed by state. (ABB)

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TEEN PREGNANCY: WHAT IS BEING DONE?

A STATE-BY-STATE LOOK

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INTRODUCTION

Helping to prevent pregnancies among young teens, and reducing the social and economic risks for teenage parents and their children, remains a very serious challenge to this nation.

We have failed to take up that challenge in an effective or comprehensive manner, either at the national, or as this report will document, at the State and local level.

This report is an effort to help us meet that challenge.

Our findings are reason for very real concern for the teenagers, for their children, and for the nation.

It is clear from this report that there is no focused approach to solving the complex problems of teen pregnancy at any level of government. The efforts that do exist are too few, uncoordinated, and lack significant support. In short, the system is broken.

Regardless of one's political philosophy, the prospect of one million teenage pregnancies, 400,000 abortions, and one-half million births each year, nearly fifty-five percent of which will be births to unmarried teens, is chilling. The human and fiscal costs to all are unacceptable.

For the teens, and their children, prospects for a healthy and prosperous life are significantly reduced.

The infants are at far greater risk of low birthweight and therefore infant mortality.

The mothers, because of poor nutrition and inadequate health care, are themselves at greater risk of poor health. We also know that one-third of these mothers will have a subsequent pregnancy while still in their teens.

The problems and risks for both pregnant teenagers and teen parents -- mothers and fathers alike -- are compounded by the fact that they are much more likely to drop out of high school before graduation. For teens who do get married, studies also confirm that they will experience higher rates of marital instability.

The result of successive risk factors such as these is often poverty, for both teen mothers and their infants. One half of this nation's Aid to Families with Dependent Children (AFDC) budget is spent on families begun when the mother was an adolescent.

These conditions, and their consequences for the teenagers, their infants, and for government, have been a major concern of the Committee.

We have surveyed the Governors of every State to determine exactly what data are available regarding teen pregnancy and parenting in their State. Although States' responses to our questionnaire, mailed on February 7, 1985, varied enormously, all but one of the 50 States cooperated with our survey.

We have sought States' views about the impact of current policies and programs. We have sought information regarding their needs, services, special projects, and initiatives. And we have asked about barriers to successful programs, as well as for recommendations on how to improve current efforts.

In this report, we have been careful to let the States speak for themselves as often as possible, both with regard to comments and data. Our conclusions are based on their responses to our survey questionnaire, in whatever form they were submitted. In a few instances, we are aware of more recent State actions or studies. If, however, this information was not reported to us in response to our questionnaire, we have not included it.

We have attempted to build an information base which will help both States and the Federal government to improve their policies. While our report has the methodological limitations inherent in all non-experimental studies, and many critical questions remain unanswered, we have learned far more about current State efforts than was previously available.

Not all solutions to the problems of teen pregnancy and parenting will or should involve the Federal government, or any government. It is obvious, however, that most States do not believe current efforts -- public or private -- are adequately funded or coordinated.

We hope that this report will help all levels of government, as well as private and church-supported organizations, to find better ways to prevent pregnancies among at-risk teens, and to craft more adequate policies and services to address the needs of pregnant and parenting teens and their children.

Failure to act now on what we know, and to pursue solutions which may still elude us, are a de facto acceptance of more private pain and more public cost.

George Miller, Chairman
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Patricia Schroeder
Lindy (Mrs. Hale) Boggs
Matthew F. McHugh
Ted Weiss
Beryl Anthony, Jr.
Barbara Boxer
Sander M. Levin
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Alan Wheat
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Lane Evans

Hamilton Fish, Jr.
Nancy L. Johnson
John R. McKernan, Jr.

FINDINGS

HIGH COSTS TO TEENS, THEIR CHILDREN, AND GOVERNMENT

HEALTH INDICATORS REMAIN POOR

Low birthweight and infant mortality rates for infants born to adolescents remain significantly higher than for other infants. In addition, for fifteen of twenty States able to report on first trimester prenatal care for teens, the percent receiving such care declined between 1980-82.

TEEN PREGNANCY COSTS BILLIONS

Data from States which have calculated the amount of public funds expended for pregnant teens, teen parents, and their children suggest that several billion dollars are spent each year for such purposes. Most State calculations included the cost for one or more of several programs, including: AFDC, Medicaid, Food Stamps, WIC, and neonatal care.

INADEQUATE INFORMATION

STATES UNABLE TO DOCUMENT EXTENT OF TEEN PREGNANCY OR THEIR RESPONSE

Beyond collecting information on the number of births to teens, States are unable to answer most basic questions related to teenagers at risk, pregnant, or parenting teens, including: where they are being served, what benefits they are receiving, who finishes high school and who finds employment.

LITTLE KNOWN ABOUT FEDERAL EFFORTS

Fewer than one-half of the States can determine the number of adolescents served, the type of service provided, or the amount of funds spent for five major federal programs which can be used to address teenage pregnancy and parenting. These are: maternal and child health, family planning, adolescent family life, Medicaid and job training.

SIGNIFICANT BARRIERS REMAIN

PREVENTION EFFORTS OVERLOOKED

Prevention programs, including family life education, pre-adolescent and adolescent education, health education, sex education, contraceptive information and services, abstinence education, as well as educational programs for the parents of high risk-teens, receive much less emphasis than programs for already pregnant and parenting teens.

COMPREHENSIVE SERVICES LACKING

While those States with initiatives are moving toward more comprehensive services, there is still little indication that most States are taking a comprehensive approach to addressing the issue of teen pregnancy and parenting.

INSUFFICIENT EDUCATION FOR TEENS AND COMMUNITIES, POOR COORDINATION, INADEQUATE FUNDING, AND INSUFFICIENT DATA MOST SERIOUS BARRIERS TO IMPROVED SERVICES

Although a variety of strategies are required to prevent adolescent pregnancy and address the needs of pregnant and parenting teens and their children, States cite lack of education and public awareness, and the lack of coordination among existing services as the most serious barriers to providing improved and comprehensive services and information for teens.

Other barriers frequently cited include inadequate funding and insufficient data necessary to target populations or determine who is receiving related services.

FEW EFFORTS TO INVOLVE TEEN FATHERS

State efforts to include adolescent males and fathers more effectively in prevention and intervention programs remain very limited. State actions to strengthen child support and paternity laws have also moved very slowly.

SOME PROMISING TRENDS

MORE STATES FOCUSING ON TEEN PREGNANCY

In the last five years, there has been a modest increase in statewide initiatives which address teen pregnancy and parenting. Seven of these States appear to have funded, or plan to fund, new, more extensive and/or comprehensive services. Twenty-three States report having either a special task force or an initiative related to pregnancy and parenting among youth.

PARENTAL INVOLVEMENT INCREASING

Efforts to expand the role of parents in teen pregnancy prevention are increasing. States report recent policy changes in schools, health clinics, and service agencies which are designed to increase parental involvement.

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February 7, 1985

Honorable George C. Wallace
Governor
State of Alabama
State Capitol
Montgomery, Alabama 36130

Dear Governor Wallace:

We are writing to request your cooperation and assistance in completing the enclosed survey. We believe this information will be very useful to members of the Select Committee on Children, Youth, and Families as we continue to address the serious problems related to adolescent pregnancy and parenthood. We hope to obtain the best available information from each State with regard to its needs, services, special projects and initiatives, as well as on the impact of national policies and programs.

We have taken this initiative because adolescent pregnancy and parenthood is one of America's critical problems, yet one for which adequate information upon which to make wise policy decisions is not always available.

We recognize that data might not be available to allow a complete response to every question. Where the requested information is incomplete or unavailable, please indicate. If you have information that is pertinent to the question, please include it, even if it is not in the form outlined.

If you or your staff have any questions or need for clarification, please contact Dr. Karabelle Pizzigati on the Select Committee staff at (202) 226-7660. Committee staff will be available to assist in completing the survey.

So that the information can be summarized and disseminated as soon as possible, the Committee would very much appreciate receiving the completed survey by March 25, 1985.

Thank you for your assistance.

Sincerely,

George Miller
GEORGE MILLER
Member of Congress

Dan Coats
DAN COATS
Member of Congress

E closure

CHAPTER I: NATIONAL PERSPECTIVES ON ADOLESCENT PREGNANCY AND PARENTING

Nationwide teen pregnancy and parenting trends, and the resulting health, educational, and employment consequences are summarized in this section, and compared to corresponding information received from the States.

Where possible, trends among teens of different ages are noted. Teens under 15 are at greatest risk. In general, older teens (18-19 year olds) are slightly more likely to have better health care and better pregnancy outcomes than are younger teens, while still falling short of health and pregnancy trends for all women.

The majority of births to all teens, are to unmarried teens. However, little data distinguishing marital status by age are available at either the national or State levels. Where these data are available, they have been included.

Unmarried teens have higher risks of having a low birthweight infant and not completing high school than married teens (69). However, regardless of marital status, teens have higher risk factors for low birthweight infants, infant mortality, inadequate or no prenatal care, school incompletion, economic self-sufficiency, and having less healthy children.

In March, 1984, there were 450,000 family groups with children, headed by married or unmarried 15-19 year olds. Nearly three-fourths (74%) of these families were living as subfamilies in another household (i.e. with their parent(s), other relatives, or friends). The other 26% maintained their own households.

Fifteen percent (66,000) of these young families were married-couple families with both parents present. Of this group, 70% (46,000) maintained their own household, while the remaining 30% lived as subfamilies.

Eighty-five percent (384,000) of these young families were headed by male or female teens whose spouse was not present. Of these, more than 80% (315,000) lived as subfamilies. Nearly 20% (69,000) established their own household (72).

BIRTH RATES TO TEENS HAVE DECLINED; PREGNANCY RATES HAVE INCREASED. STILL, ONE-HALF MILLION TEENS GIVE BIRTH EACH YEAR: MOST REMAIN AT GREATER SOCIAL AND ECONOMIC RISK

In 1983, the number of births to teens under twenty was just under one-half million (499,038), accounting for almost 14 percent of all births. Most teenage pregnancies in the United States are unintended (58, 62). In addition, one-third of all teen mothers will experience a subsequent pregnancy while still in their teens (52).

Each year since 1972, the birth rate and the actual number of births to teens have been declining, even for the youngest teens. The rate, however, has been declining more slowly than has the rate of births to older women, and the U.S. still has a higher teenage birth rate than in most other developed countries (58). Also, while the overall teen birth rate is declining, some States report increases in the number of births to teens. Between 1978 and 1983, six States showed increases among 15-19 year olds (Arizona, Florida, Illinois, New Mexico, North Carolina, Oklahoma).

Birth Rates Vary Depending on Age of Mother

Most teen births are to women age 15-19. (See Table 1).

Teens Under 15. Births to teens under 15 constitute a very small percentage of all births (less than one-half of one percent). While births to teens under 15 were about 7500 in 1960, they rose to almost 13,000 in 1973. During the latter half of the 1970's, however, the number of births to all teens began a decline. In 1983, the latest year for which final natality statistics are available, the number of births to this group dropped to 9,752 (60, 78).

15-17. The number of births and the birth rates for this group have been declining since the early 1970's. (1983 Total: 172,673 births; birth rate, 32 live births/1000 women age 15-17. 1970 Total: 223,590 births; birth rate 38.8/1000.)

18-19. Births and birth rates have fallen fastest for this age group. (1983 Total: 316,613 births; birth rate, 78.1 live births/1000 women aged 18-19. 1970 Total: 421,118 births; birth rate 114.7/1000.)

Births to Unmarried Teens Continue to Grow

The percent of births to unmarried teens is growing. While the actual number of births to teens and birth rates declined during the seventies, the births to unmarried teens rose (Table 3 and Figure 2).

By 1983, more than half of births to teens (54%) were to unmarried teens, as contrasted with 15% in 1960, and births to unmarried teens accounted for nearly 40% of all births to unmarried women. Of all births to unmarried teens, 43% were births to 15-17 year olds; 54% were births to 18-19 year olds; and 3% were to teens under age 15 (78).

Seventeen States reported, for at least one year, the number of not married parenting mothers/adolescents or the number or percent of births to unmarried teens (See State Fact Sheets, beginning on page 120).

Birth Rates Vary for White/Minority Teens

The rate of teenage childbearing among black teens is much higher than among white teens (Table 2). Black adolescents also begin childbearing at younger ages than whites, increasing the likelihood of subsequent births during the teenage years.

The overall rise in births to unmarried teens, however, is due to increases in rates for whites. There has been a downward trend for births to unmarried black teens, though their rates are still significantly higher than for whites (Table 3 and Figure 5).

OVERALL TEENAGE PREGNANCY RATES ROSE DURING THE 1970's, BUT HAVE SLOWED SINCE 1979

Most demographers agree that the pregnancy rate is calculated by adding the birth rate, the abortion rate, and the miscarriage rate.

Birth rates are collected and published by the National Center for Health Statistics in their annual "Advance Report of Final Natality Statistics." Abortion data are available from the Alan Guttmacher Institute. No Federal laws require reporting for abortion. However, the Centers for Disease Control conduct periodic surveys and the Alan Guttmacher Institute supplements them with their own survey data. The National Institute for Child Health and Human Development (NICHD), which calculates pregnancy rates, relies on these two major sources.1/

Between 1974 and 1979 the pregnancy rate per 1000 women aged 15-19 increased from 99 to 109, a 10% increase. In 1982, the pregnancy rate was 112 per 1000 women aged 15-19, representing a 2.8% increase since 1979 2/ (See Fig. 1). If the rate of conception, however, takes into account only the number of sexually active women as the group at risk rather than all women in that age group, there was a 6.5% decline in the rate of conception, from 232 to 217 per 1000 sexually active women 15-19, between 1974 and 1979. In 1982, the pregnancy rate rose to 235 per 1000 sexually active women age 15-19, representing virtually no change since 1974 (59) 2/.

1/ "The Centers for Disease Control report abortion surveillance data compiled from central state agencies and from hospitals or facilities in which abortions are performed. The Alan Guttmacher Institute reports the number of abortions based on a survey of health institutions and private physicians providing abortion services. Because the latter figure includes abortions performed in physician's offices, it is higher than the Centers for Disease Control figure. The distribution of abortions by characteristics of the women is available from the Centers for Disease Control, and the two data sources may be combined to give estimates of the total number of abortions performed on women with given characteristics, such as age or marital status" (62). AGI performs these calculations and these numbers are used by NICHD.

2/ For 1982, abortion data are estimated. Final data are not yet available.

Each year since 1974, over one million teenagers have become pregnant (51).

Other data, from a 1980 survey, showed that 8.5% of metro-area, never-married, sexually-active women aged 15-19 in 1981 reported having been pregnant compared to 16.2% in 1979 (79). 3/

Sexual activity among female 15-19 year olds increased dramatically in the 1970's, but has leveled off since 1979.

Sexual activity is defined as "ever having had intercourse." In 1976, of those ever having had intercourse, the majority of 15-19 year olds had had intercourse more than once. The data from two national surveys (1971 and 1976) and a third survey of women living in metropolitan areas conducted in 1979 show substantial increases in sexual activity among never-married women 15-19 years of age, from 27.6% in 1971 to 46.0% in 1979, a 66.7% increase. In 1982, however, the National Survey of Family Growth Cycle III, showed that sexual activity among never-married women 15-19 years of age in metropolitan areas declined to 42.2%, indicating a leveling off since 1979. NICHD uses this information to extrapolate to an estimated number of sexually active women in their calculation of pregnancy rates per 1000 sexually active women aged 15-19.

3/ This survey included self-reported data. Self-reporting surveys of pregnancy have been shown to produce underestimates of pregnancy rates. In addition, abortion data were not available in 1971 for comparison purposes. Therefore, this percentage is probably an underestimate of the actual percentage of never-married women 15-19 who were pregnant.

FEDERAL, STATE, AND LOCAL EXPENDITURES FOR TEEN PREGNANCY AND PARENTHOOD REMAIN VERY HIGH

In addition to the greater economic hardships and diminished opportunities faced by most teen parents, governmental services and supports for pregnant teens, teen parents, and their children require large expenditures of public funds.

The Congressional Budget Office recently cited two studies which contain estimates of such expenditures:

-- An Urban Institute Study estimated that, in 1975, the federal government spent $8.55 billion in AFDC benefits, Medicaid, and Food Stamps on AFDC households where the mother was a teenager when she had her first child (51).

-- A SRI International study estimated that each of the 442,000 first teenage births in 1979 would cost Federal, State, and local governments an average of $18,700 every year over the next 20 years in additional health and welfare costs (51).

Some States have also calculated the cost of adolescent pregnancy:

Illinois

The Executive Service Corps has estimated that teenage pregnancy costs the citizens of Illinois $853 million each year. The largest cost areas are AFDC and Medicaid, general support for non-AFDC children, child care for working teen mothers, birth and newborn costs, and medical attention for children not on aid. Individuals in Illinois pay 71% of the total (cash outlays, higher taxes, higher costs passed along by business), or more than $200 for each household. Business pays the remaining amount (56).

California

Annual Medi-Cal costs for delivering the children of pregnant teens, for neonatal intensive care, and for rehospitalization costs exceed $105 million each year. A ten percent increase in the number of teen mothers completing high school would reduce welfare costs by $53 million. If AFDC teen mothers were one year older at the time of the first pregnancy, $150 million would be avoided in welfare costs [5 (b)].

South Carolina

The cost of 2,458 first live births in 1981, including the estimated Medicaid, WIC, and welfare costs for one year, is $13,147,030. The cost per teen is conservatively estimated to be $5,349 per year.

Projected through 1990, the total costs reach $90,585,378, or $36,853 per 1981 teen births for AFDC and Food Stamp costs alone. Also, it is estimated that approximately 2500 more teen births in 1983 will generate an additional $90 million in public costs by 1990 [39(d)].

Connecticut

Fifty-eight percent of the December 1984 AFDC caseload were women who bore their first child as an adolescent. These 21,654 female heads-of-household represent a potential annual state cost of $50 million [7(a)].

Colorado

An AFDC family headed by a mother who had her first child as a teenager costs the public about $8000 per year. Assuming this family will receive AFDC for three years, costs for each teenager total $24,000 (6).

Michigan

In January, 1985 there were 15,319 AFDC or General Assistance cases in which the recipient was under 20. Monthly expenditures for them totalled, on an annualized basis, $92,197,910. [AFDC/GA ($4,414,345), Food Stamps ($1,287,916), and Medical Assistance ($1,980,899), totalling $7,683,160 per month] [22(a)].

Texas

The Texas House Select Committee on Teenage Pregnancy estimated (1982) the first year cost for a child born to a teenage mother to be $4600. They also estimate that sixty-five percent of these costs are assumed by the public sector, and that approximately $1,644 of this cost is directly related to delivery [42(a)].

HEALTH: TEEN MOTHERS RECEIVE INADEQUATE PRENATAL CARE; INFANTS BORN TO TEEN MOTHERS LESS HEALTHY

More is known on a nationwide basis about health outcomes for infants of teen mothers, such as low-birthweight rates, and health practices of teen mothers, such as access to prenatal care, than is known about the other indicators usually applied to this group, including information about high school dropout rates or unemployment rates.

It is known, for example, that infants born to teenage mothers, particularly those aged 17 years and under, are considerably more likely to have low APGAR scores (a summary measure used to evaluate newborn infants overall physical condition at birth) than infants born to mothers age 17-40 (78).

For all but the very youngest teens, poor birth outcomes, including low birthweight and infant mortality, may be attributable to inadequate or no prenatal care, and inadequate nutritional supplementation. In addition, teens may also have little or no information about nutritional needs or information about alcohol use or cigarette smoking during pregnancy (52). The Institute of Medicine has confirmed that, "... being young biologically is not an independent risk factor for low birthweight and that the increased risk probably comes from other attributes of teenager mothers -- such as low socioeconomic status, poor nutritional status, and late receipt of prenatal care" (53).

In addition to poor nutritional status, many other medical complications that are prevalent among teens during pregnancy, such as toxemia, anemia, and prolonged labor, could be ameliorated with better access to early comprehensive prenatal care (51, 52).

Early Prenatal Care Declines

National data reveal that only about half of all pregnant teens who give birth receive prenatal care in the first trimester of pregnancy, compared to 76% of all mothers who begin prenatal care in the critical first trimester (78) (Table 4). Neither national data nor data reported by States provide information about entry into prenatal care by marital status and age of mother.

Data reported from the States confirm the national trend. Of the 22 States able to provide data on the percentage of pregnant adolescents receiving prenatal care within the first trimester in 1982, all but two States reported within a range of 48% to 64%. New Mexico reported a percentage of 22.3% in 1981, which increased by 17% in 1983. Virginia reported that only 32% of pregnant teens received early prenatal care in 1982, decreasing to 31% in 1983. Four States, Louisiana, Vermont, Wisconsin, and Wyoming served more than 60% of pregnant teens in the first trimester during 1982 (Table 4A).

Twenty States were able to report the percentage of live births to adolescent women receiving prenatal care in the first trimester for three or more consecutive years (Georgia, Illinois, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Nebraska, North Dakota, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Vermont, Virginia, Washington, West Virginia, Wyoming).

Of these, 16 included data for 1978. Between 1978 and 1980, 13 States reported increases in the percentage of adolescent women who gave birth and received prenatal care in the first trimester (Illinois, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, Nebraska, North Dakota, North Carolina, Pennsylvania, Tennessee, Vermont, West Virginia).

Eight States, however, had a decline in rates between 1980 and 1983 (Illinois, Minnesota, Missouri, Nebraska, Ohio, Pennsylvania, Virginia, and Washington).

An additional 7 States had declines in the percentage of live births to adolescent women who received prenatal care in the first trimester between 1980 and 1982, but 6 of these reported slight improvements for 1983 [Tennessee, Maryland, Georgia, Louisiana, Mississippi, North Dakota, Oklahoma (reported no 1983 data)].

Kentucky and Wyoming showed improvements in these rates between 1980 and 1982, but decreases in 1983.

Only Vermont, North Carolina, and West Virginia showed a steady rate of improvement between 1978 and 1983.

Mortality More Likely for Infants of Teens

Infant mortality rates by age of mother have only been collected for selected years or for certain regions. Consequently, the national population-based data on infant mortality remain sparse.

No national data are currently collected on infant mortality by marital status of the mother. 4/

Many States have recently begun to collect infant mortality data by linking birth and death certificates. Twenty-five States were able to provide this information for at least one year (See Table 5). While these data are not absolutely comparable because of differences in reporting format and incomplete matching of birth and death certificates, they are indicative of severe health outcomes for infants born to teens. The nationwide infant mortality rate for infants born to mothers of all ages was 11.2/1000 live births in 1983, down only slightly from 11.5 in 1982. For those States able to report infant mortality rates (1982) for teens (under 15, 15-17, 18-19), the rates are much higher than the national rate (Table 5).

Low Birthweight Rates Greater for Infants of Teens

Low birthweight, which is strongly associated with infant mortality, remains high among infants born to teens (53). Teenage mothers typically account for about 1 in 5 low birthweight infants (78). In 1983, there were 47,500 low birthweight infants born to teens under age 20, almost 10% of all births to teens. There has been little or no reduction in low birthweight rates among infants born to teens since 1978 (Table 6).

4/ National Center for Health Statistics, Mortality Branch has begun a pilot study in 9 states using a 1982 cohort to test the feasibility of collecting infant mortality by age of mother. Preliminary results should be available by Spring 1986.

"Unmarried mothers have a consistently higher risk of bearing a low-birthweight infant than those who are married (but) the increased risk is not explained by age differences among married and unmarried women" (53). The differential in low birthweight between married and unmarried women is greater for older mothers than for teen mothers (69) (See Figure 3).

Most States were able to report the incidence of low birthweight by age of mother. In nearly every State which reported, the percent of low birthweight infants born to teens substantially exceeds the average for all births (Table 6A).

EDUCATION AND INCOME: TEEN PARENTS ARE AT HIGHER RISK OF POVERTY, SCHOOL FAILURE AND UNEMPLOYMENT

School Completion Extremely Low for Pregnant and Parenting Teens

Teenagers who give birth while still in high school, or soon after leaving school, are less likely to obtain a high school degree or an equivalent than are women who delay childbearing (67).

In 1982, the four most frequently cited reasons by female students for dropping out of school were: "I got married or planned to get married" (31%); "school was not for me" (31%); "had poor grades" (30%); and "pregnancy" (23%) (50).

In addition, married mothers under age 20 are more likely to be high school graduates than unmarried mothers under age 20. This also holds true for mothers 20 years of age and older (69) (See Figure 4).

Sometimes pregnant teens drop out of school by choice. However, they are often forced out by mandatory school policies, discriminatory attitudes, and/or lack of child care and flexible schedules [21(a), 71].

Only six States were able to report the number and/or percentage of female students who left school and who gave pregnancy, parenting, or lack of child care as the reason for dropping out (Indiana, Louisiana, Mississippi, New Mexico, Wisconsin, West Virginia).

Tracking the number of adolescents who drop out of school is still not a priority for most Federal, State, and local educational agencies although such information would assist in the planning of prevention strategies, since many teens who drop out are at risk after leaving school.

Joblessness, Poverty, the Norm for Teen Parents

Families headed by teen parents, either single or married, face a greater likelihood of economic hardship than other families. One study showed that while initially more adolescent fathers were working than their classmates, at jobs of about equal prestige for higher income, their classmates' incomes were higher and their jobs more prestigious after eleven years out of high school (64). Families headed by young mothers are seven times more likely to be living below the poverty level than other families (52).

Ten States reported, for at least one year, the number of pregnant and parenting adolescents receiving Aid To Families with

Dependent Children (See Table 8). South Carolina reported that in 1979, 18.6% of the mothers receiving AFDC were under twenty years of age, compared to 7.4% nationally. South Carolina may have the highest percentage of teens receiving welfare [39(d)].

The relationship between educational attainment and economic well-being is strong. In general, students without a high school diploma are much more likely to find employment in low-skill, low wage jobs [20(a), 21(a), 22(a), 52].

States rarely keep statistics regarding the economic well-being of teen parents. Only Arizona was able to provide unemployment rates among adolescent mothers and fathers.

Studies confirm that teens who perceive poor future job prospects may be more likely to speed up childbearing [20(a), 61]. Fifteen States provided information on the overall statewide youth unemployment rate.

Teen mothers who drop out of school generally have extreme difficulty in escaping poverty, particularly if they are unmarried. Limited job and child care opportunities, and lack of skills combined with the need for added resources very often force teen mothers into the welfare system. In 1975, nearly two-thirds of women receiving AFDC had their first child when they were teenagers (51).

"Some (single teenage and school-age mothers') immediate economic problems are solved by remaining with their parents, and most teenage mothers do so at least for a time. Few head their own households. Thus, because the poverty rate for those teenage mothers who head their own households is very high, usually 100 percent (or close to it), most families headed by teenage mothers live as subfamilies in the household of a relative, usually a parent. Those who live on their own constitute only 4 percent of poor mother-only families. Some teenage mothers move out of poverty subsequently through marriage" (70).

TEEN PARENTS SUFFER HIGHER RATES OF MARITAL INSTABILITY, AND THEIR CHILDREN ARE MORE LIKELY THAN OTHER CHILDREN TO HAVE HEALTH AND LEARNING PROBLEMS, AND TO BE TEEN PARENTS THEMSELVES

Teen Parents Have Higher Rates of Divorce

Teenage mothers, when compared to women giving birth at later ages, suffer higher rates of marital separation, divorce and remarriage (60). Although an unmarried adolescent mother is likely to marry soon after the child is born, her marriage is more likely than others to end in divorce (60). "Marital dissolution rates are higher the younger the adolescent is at the time of marriage, and those who marry young are likely to express regrets later about the marriage. The risk of marital dissolution is carried on through later life, and shows up in increased risks of marital dissolution in second marriages" (60).

Economic Support, Involvement by Teen Fathers Inadequate

According to one study, fewer than one-fourth of the fathers of infants of unmarried teenage mothers were in weekly contact with the child's mother during the first years of the child's life, with less contact in subsequent years (60). Additional studies support the conclusion that few young unmarried mothers receive economic support from the father (60). Adolescent fathers also tend to drop out of school earlier and take low paying jobs, limiting their ability to provide child support (51, 60). In fact, during 1978 only 16% of all single mothers between the ages of 18 and 24 received child support (51).

Another recent study, however, suggests that teenage fathers may be more involved than previously thought. In a nationwide study of 400 teen fathers, 82% reported having daily contact with their child, even though they lived apart, and 74% said they contributed financially to the child's support. Nearly 90% said they had ongoing relationships with the mother (54, 55).

Children of Teen Parents Are Less Healthy

Children of teen parents tend to be less healthy on the average than other children, and to exhibit learning difficulties more frequently in school. They also are likely to become teen parents themselves (52, 61).

One study, measuring infants' status at age one, found that children of parents with low socioeconomic status, and children of unmarried mothers who live alone with their children, generally show poorer physical health (64).

Additional studies show that children born to teenagers are more likely to show cognitive deficits; much, but not all, of the effect resulting from the social and economic consequences of early childbearing. Research also suggests that the effect of the mother's age on her child's social and emotional development is less clear than it is on her child's cognitive development. It appears that when an effect on social and emotional development was present, it was negative, and often was not evident until the child neared school age. As with other effects, however, "the evidence suggests that this effect does not result from the mother's age at birth directly, but rather is transmitted through other factors associated with early childbearing, such as educational and economic disadvantage and greater likelihood of marital breakup" (64).

Studies have shown, however, that certain health and education programs can ameliorate these hardships. Adverse effects are also less likely to occur when the teenage mother has a supportive network -- including help from the father, her own parents, or others (64).

Research "suggests that one way to help the children of adolescents is to improve the educational and employment opportunities of the teenage parents and to encourage the supporting role of other adult family members (64)." (52).

ADOPTION, AS AN ALTERNATIVE TO TEENAGE PARENTING, DECLINES

There are little available data on the frequency with which children of adolescents are placed for adoption. It is generally believed that adoption has diminished in frequency over the last decade. While adoption is not prevalent in either group, it is more prevalent among whites than blacks (60).

The national survey data that are available show that in 1971, 8% of infants born to unmarried teenagers were placed for adoption; 2% of the unmarried black teenagers and 18% of the unmarried white teenagers who gave birth placed their children for adoption. By

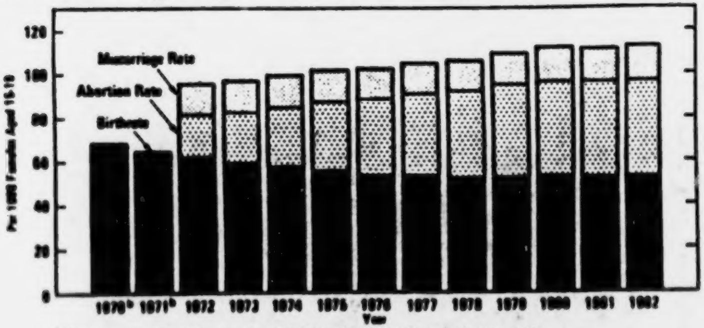
1976, only 3% were placed. The rate for whites had declined to 7%, and the black rate to zero (57).

The third cycle of this national survey revealed that 5% -- a slightly higher percent of births to teens than in 1976 -- had been placed for adoption in 1982. This "is the result of changing racial composition of premarital births: In 1982, white babies, which had been placed for adoption at higher rates than black babies, made up a larger proportion of all premarital births. The percents of white and black babies placed for adoption that were observed in the 1982 survey were virtually identical to those observed in 1976" (57).

Most States do not keep data on the rate of adoptions by age of the biological mother. Only three States reported some information on the number of adolescents choosing adoption (Arkansas, Delaware, and Mississippi).

Figure 1

Adolescent Pregnancy Rate and Outcomes, 1970-1982[a]



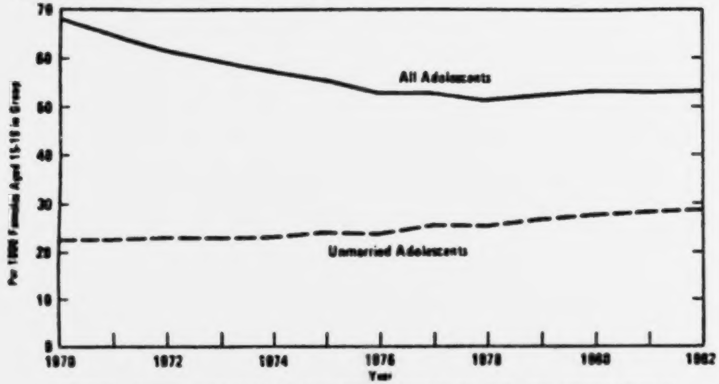
[a] The pregnancy rate is the sum of the birthrate, abortion rate, and miscarriage rate.

[b] Pregnancy, abortion, and miscarriage data are not available before 1972 because abortion was not legal in many areas at that time.

SOURCE: Congressional Budget Office. Pregnancy and abortion data from the Alan Guttmacher Institute, unpublished data. Birth data from National Center for Health Statistics, *Advance Report of Final Natality Statistics, 1982*, vol. 33, no. 6, Supplement (September 28, 1984), p. 16.

Figure 2

Adolescent Birthrates, 1970-1982



SOURCE: Congressional Budget Office, from National Center for Health Statistics, *Advance Report of Final Natality Statistics 1982*, vol. 33, no. 6, Supplement (September 28, 1984), pp. 16 and 31

Table 1. Number of Births to Adolescents by Age of Mother

Age	1960*	1970*	1972	1975	1978	1980	1983
Total births Under 15	7,462	11,752	12,082	12,642	10,772	10,169	9,752
15-17	177,904	223,590	236,641	227,270	202,661	198,222	172,673
18-19	423,775	421,118	379,639	354,968	340,746	353,939	316,613
Total	609,141	656,460	628,362	594,880	554,179	562,330	499,038

Source: National Center for Health Statistics, Advance Report of Final Natality Statistics, 1972, 1975, 1978, 1980, 1983

*See Reference (65).

Table 2. Birth Rates by Age of Mother and Race of Child: U.S. 1970-83

Age of Mother Year and race of child	10-14 yrs.	Total	15-17 yrs.	18-19 yrs.
All races				
1983	1.1	51.7	32.0	78.1
1982	1.1	52.9	32.4	80.7
1981	1.1	52.7	32.1	81.7
1980	1.1	53.0	32.5	82.1
1979	1.2	52.3	32.3	81.3
1978	1.2	51.5	32.2	79.8
1977	1.2	52.8	33.9	80.9
1976	1.2	52.8	34.1	80.5
1975	1.3	55.6	36.1	85.0
1974	1.2	57.5	37.3	88.7
1973	1.2	59.3	38.5	91.2
1972	1.2	61.7	39.0	96.9
1971	1.1	64.5	38.2	105.3
1970	1.2	68.3	38.8	114.7
White				
1983	0.6	43.6	24.8	68.3
1982	0.6	44.6	25.2	70.8
1981	0.5	44.6	25.1	71.9
1980	0.6	44.7	25.2	72.1
1979	0.6	43.7	24.7	71.0
1978	0.6	42.9	24.9	69.4
1977	0.6	44.1	26.1	70.5
1976	0.6	44.1	26.3	70.2
1975	0.6	46.4	28.0	74.0
1974	0.6	47.9	28.7	77.3
1973	0.6	49.0	29.2	79.3
1972	0.5	51.0	29.3	84.3
1971	0.5	53.6	28.5	92.3
1970	0.5	57.4	29.2	101.5
Black				
1983	4.1	95.5	70.1	130.4
1982	4.1	97.0	71.2	133.3
1981	4.1	97.1	70.6	135.9
1980	4.3	100.0	73.6	138.8
1979	4.6	101.7	75.7	140.4
1978	4.4	100.9	75.0	139.7
1977	4.7	104.7	79.6	142.9
1976	4.7	104.9	80.3	142.5
1975	5.1	111.8	85.6	152.4
1974	5.0	116.5	90.0	158.7
1973	5.4	123.1	96.0	166.6
1972	5.1	129.8	99.5	179.5
1971	5.1	134.5	99.4	192.6
1970	5.2	147.7	101.4	204.9

Source: NCHS, Advance Report of Final Natality Statistics, 1983, Table 4, Vol. 34, No. 6 [Supple], 1985.

Table 3. Birth Rates for Unmarried Women Age 15-19 by Race of Child (Live births to unmarried women per 1000 unmarried women 15-19 years of age)

Year 1/	All Races	Black	White
1970	22.4	96.9	10.9
1971	22.3	98.6	10.3
1972	22.8	98.2	10.4
1973	22.7	94.9	10.6
1974	23.0	93.8	11.0
1975	23.9	93.5	12.0
1976	23.7	89.7	12.3
1977	25.1	90.9	13.4
1978	24.9	87.9	13.6
1979	26.4	91.0	14.6
1980	27.6	89.2	16.2
1981	28.2	86.8	17.1
1982	28.9	87.0	17.7
1983	29.7	86.4	18.5

1/ For 1970 to 1979, births to unmarried women are estimated from data for registration areas in which marital status of mother was reported. For 1980 to 1983, data for states in which marital status was not reported have been inferred and included with data from the remaining states.

Source: NCHS, Advance Report of Final Natality Statistics, 1983, Table 18, Vol 34, No. 6 [Supple.], 1985.

Table 4. Live Births by Month of Pregnancy Prenatal Care Began for Women Age 15-19

Year	Total	Month 1 & 2	3	4-6	7-9	No prenatal Care	Not Stated
1983	489,286 (100%)	143,655 (29.4%)	114,378 (23.4%)	163,596 (33.4%)	39,499 (8.1%)	15,417 (3.2%)	12,741 (2.6%)
1980	552,161 (100%)	166,814 (30.2%)	133,021 (24.1%)	177,871 (32.2%)	41,042 (7.4%)	14,058 (2.5%)	19,355 (3.5%)
1978	538,799 (100%)	153,105 (28.4%)	130,273 (24.2%)	177,628 (33.0%)	40,426 (7.5%)	13,808 (2.6%)	23,559 (4.4%)
1975	502,613 (100%)	133,286 (26.5%)	122,020 (24.3%)	171,523 (34.1%)	40,900 (8.1%)	11,021 (2.2%)	23,863 (4.7%)
1972	616,280 (100%)	162,698 (26.4%)	153,454 (24.9%)	226,175 (36.7%)	57,314 (9.3%)	16,639 (2.7%)	N/A N/A

Source: National Center for Health Statistics, Advance Report of Final Natality Statistics, 1972, 1975, 1978, 1980, 1983.

Table 4A: Percent of Live Births to Adolescent Women Receiving Prenatal Care in First Trimester, by State
(as reported by states)

State	Statewide Percentage* 1/ (all age mothers) 1983	1978	1980	1982	1983
Georgia	75.2	57.7 (1979)	54.8	51.3	53.2
Illinois	77.8	53.0	54.8	53.8	53.7
Kansas	81.2		70.0 (1980-81-82)		
Kentucky	75.0	48.7	52.2	55.6	55.4
Louisiana	78.3	50.0	62.7	61.2	62.7
Maryland	78.5		59.5	55.7	55.8
Minnesota	79.0	52.6	52.8	49.7	49.3
Mississippi	74.6	55.4	58.4	56.4	57.1
Missouri	79.2	56.5	58.3	56.1	55.3
Nebraska	80.6	53.3	55.9	55.6	54.9
New Hampshire	84.8		64.0		
New Jersey	80.7		50.0	50.9	
New Mexico	61.5			22.3 (1981)	26.0
North Carolina	77.8	53.9	55.5	56.7	57.1
North Dakota	81.5	50.9	59.7	58.7	60.6
Ohio	81.0		59.3	58.9	58.9
Oklahoma	67.4	51.5**	50.0**	49.1**	
Pennsylvania	79.0	53.7	53.8	52.5	49.9
Rhode Island	84.7			65.7 (1976-82)	
South Dakota	72.1				51.4
Tennessee	74.7	49.5	53.8	51.3	51.6
Vermont	82.9	57.0	59.0	62.0	64.0
Virginia	80.6	33.0 (1979)	33.0	32.0	31.0
Washington	77.6	55.8***	58.3	53.4	52.6
West Virginia	72.0	45.6	47.7	48.7	49.4
Wisconsin	83.8			60.6	
Wyoming	78.7	60.0	59.6	61.9	59.5

1/ Overall state rate for all live births in 1983 to pregnant women of all ages who received prenatal care in the first trimester.

*Source: NCHS, Unpublished data, 1985.

** Of those reporting
*** For 1978 only, first trimester care for teens is by occurrence, and births are for residence.

Table 5. State Infant Mortality Rates By Age of Mother
(rates may be per 1000 live births or 1000 live births in age group as reported by States; See Footnotes).

STATE AND AGE OF MOTHER	Statewide IMR++ 1/ (all age mothers) 1983	1978	1980	1982	1983
ARIZONA	9.5				
10-14		28.0+			
15-19		11.0+			
CALIFORNIA	9.7				
10-14		22.64	20.86	28.24	N/A
15-19		16.05	14.62	12.59	N/A
18-19		N/A	N/A	12.3	N/A
CONNECTICUT	10.1				
Under 19				16.3	
GEORGIA	13.4				
10-14		N/A	N/A	15.9*	N/A
15-17		N/A	N/A	17.8*	N/A
18-19		N/A	N/A	14.7*	N/A
HAWAII	9.4				
10-14		0.0	58.8	0.0	0.0
15-17		15.4	14.3	11.4	14.2
18-19		11.4	9.9	13.5	12.5
ILLINOIS	12.4				
10-14		46.0	41.1	25.3	N/A
15-17		21.6	21.5	21.5	N/A
18-19		18.6	18.3	17.4	N/A
KANSAS	10.3				
10-14			19.2* for 1980-81-82		
18-19			11.7* for 1980-81-82		
LOUISIANA	13.5				
10-14		41.7**	24.7**	N/A	N/A
15-17		25.0**	18.9**	N/A	N/A
18-19		19.0**	15.3**	N/A	N/A
MARYLAND	11.8				
10-14			19.0	37.0	
15-17			20.3	15.7	
18-19			16.1	14.3	
MINNESOTA	9.8				
10-14		N/A	-	-	N/A
15-17		N/A	16.1	16.9	N/A
18-19		N/A	15.0	16.1	N/A

STATE AND AGE OF MOTHER	Statewide IMR++ 1/ (all age mothers) 1983	1978	1980	1982	1983
MISSISSIPPI	15.1				
10-14		N/A	N/A	46.4	36.0
15-17		N/A	21.6	23.7	20.5
18-19		N/A	18.2	19.4	15.7
MISSOURI	10.7				
10-14		31.6*	45.5*	27.2*	47.9*
15-17		22.3*	16.6*	19.4*	19.6*
18-19		22.2*	17.4*	12.2*	13.5*
MONTANA	9.0				
10-14			0.0	153.8	
15-17			23.7	18.3	
18-19			19.3	7.0	
NEBRASKA	9.9				
10-14		71.4	0.0	30.3	0.0
15-17		23.9	13.6	21.4	18.7
18-19		15.7	14.2	13.9	13.4
NEW JERSEY	11.5				
10-14		N/A	17.1	24.4	N/A
15-19		N/A	18.5	18.2	N/A
NEW MEXICO	10.0				
10-14				12.8 (1981)	
15-17				14.3 (1981)	
18-19				13.1 (1981)	
10-19		13.8	11.0		
NORTH CAROLINA	13.2				
10-14		32.1	32.5	24.7	25.7
15-17		25.8	19.7	19.2	21.2
18-19		22.4	16.8	16.2	17.7
NORTH DAKOTA	8.9				
10-14		111.1	0.0	0.0	0.0
15-17		23.6	15.2	7.0	17.1
18-19		10.9	18.1	14.0	10.5
OKLAHOMA	10.9				
10-14		37.5***	38.3***	25.3***	37.9***
15-17		19.6***	18.7***	14.3***	15.6***
18-19		17.1***	14.7***	14.7***	12.0***

STATE AND AGE OF MOTHER	Statewide IMR++ 1/ (all age mothers) 1983	1978	1980	1982	1983
PENNSYLVANIA	11.3				
10-14			43.2*		
15-17			17.1*		
18-19			14.5*		
RHODE ISLAND	11.7				
10-14			25.2+ (1976-1982)		
15-17			12.4+ (1976-1982)		
18-19			10.8+ (1976-1982)		
SOUTH CAROLINA	15.0				
10-14		N/A	55.7	23.0	
15-19		N/A	23.3	22.8	
TENNESSEE	12.8				
10-14		61.3**	27.5**	24.0**	55.1**
15-17		23.1**	18.5**	20.7**	18.6**
18-19		19.3**	16.3**	15.8**	18.3**
VERMONT	8.7				
10-14		0.0	0.0	0.0	0.0
15-17		29.9	24.2	25.1	12.4
18-19		20.8	14.2	17.3	8.3
WASHINGTON	9.5				
10-14		N/A	28.3	N/A	N/A
15-17		N/A	18.8	N/A	N/A
18-19		N/A	13.3	N/A	N/A
WISCONSIN	9.6				
10-14				4.4****	
15-17			24.5	19.2	
18-19			16.2	11.7	

* Infant mortality rate reported as per 1000 live births.

** Rates reported per 1000 live births in age group; numerators include only those infants deaths which could be matched to birth certificates (85-95%).

*** Infant mortality reported as ratio of matched deaths to total deaths per 1000 births.

**** Too few deaths (4) to be statistically significant.

* Rates are for single live births.

** Rates per 1000 live births age specific.

+ Rates reported are neonatal mortality rates (per 1000 live births)

1/ Infant deaths per 1000 live births in 1983.

++ Source: National Center for Health Statistics, Monthly Vital Statistics Report, Advance Report of Final Mortality Statistics, 1983, Table 13, Vol. 34, No. 6 [Supple] 1985.

Table 6. Percent of Low Birthweight by Age of Mother 1/

	1978	1980	1983
Age of Mother			
Under 15	14.3	14.6	14.5
15-19 yrs.	9.9	9.4	9.4
15 yrs.	12.1	12.1	12.0
16 yrs.	11.1	10.7	10.7
17 yrs.	10.3	10.0	10.0
18 yrs.	9.7	9.4	9.4
19 yrs.	9.0	8.4	8.4
20-24 yrs.	7.1	6.9	7.0
25-29 yrs.	6.0	5.8	5.9

1/ Less than 2500 gm.

Source: National Center for Health Statistics, Advance Report of Final Natality Statistics, 1978, 1980 and 1983.

Table 6A: **Percentage of Teen Births Which Are Low Birthweight, by State and Age of Mother** (as reported by states)

State and Age of Mother	Statewide LBW* 1/ (all age mothers) 1983	1978	1980	1982	1983
Alabama	7.9				
10-14		16.7	19.4	13.5	15.3
15-17		12.0	10.7	11.5	11.1
18-19		10.1	9.3	9.6	10.0
Alaska	4.7				
10-14		8.3	0.0	N/A (1981)	
15-19		7.0	6.7	N/A (1981)	
10-19		N/A	N/A	6.0 (1981)	
Arizona	6.1				
10-14		7.4	14.5	16.0	17.1
15-19		7.9	7.4	6.8	8.4
California	6.0				
10-14		20.0	17.7	16.4	N/A
15-17		N/A	N/A	8.3	N/A
18-19		N/A	N/A	7.3	N/A
Connecticut	6.4				
10-14		20.0	N/A	12.2	13.1
15-17		12.3	N/A	12.7	12.7
18-19		10.0	N/A	9.2	9.7
Georgia	8.4				
10-14		14.7	16.5	18.2	14.6
15-17		12.0	13.1	12.9	11.9
18-19		11.1	10.6	10.3	9.9
Hawaii	7.0				
10-14		10.0	5.9	9.1	21.0
15-17		10.1	10.9	10.3	10.6
18-19		10.0	10.3	10.6	9.2
Idaho	5.6				
14-17			9.0 (Average 1969-1982)		
Illinois	7.2				
10-14		12.4	16.6	16.1	15.3
15-17		11.4	11.1	11.4	11.3
18-19		9.9	9.3	9.3	9.9
Indiana	6.3				
10-14			11.1	14.6	16.9
15-17			7.7	8.8	16.9
18-19			7.2		

State and Age of Mother	Statewide LBW* 1/ (all age mothers) 1983	1978	1980	1982	1983
Iowa	5.0				
10-14		16.0	10.0	6.7	
15-19		7.6	8.3	5.8	
Kansas	6.1				
10-14		13.9	15.3	11.5	12.2
18-19		9.0	7.7	8.3	8.3
Kentucky	6.9				
10-14		13.7	14.5	16.7	13.8
15-17		8.9	8.9	9.5	9.5
18-19		8.5	8.8	8.1	7.9
Louisiana	8.6				
10-14		16.0	14.6	15.8	20.4
15-17		11.9	12.6	11.7	12.8
18-19		10.5	10.8	10.2	10.8
Maine	5.6				
10-14		5.3	8.7	21.4	6.7
15-17		8.1	7.3	7.9	9.6
18-19		6.0	6.0	7.0	7.1
Maryland	7.7				
10-14		14.3	18.1	15.8	15.3
15-17		12.1	11.8	11.0	12.8
18-19		10.0	10.6	10.2	10.3
Massachusetts	5.9				
10-15					13.2
16-17					8.7
18-19					7.9
Michigan	7.0				
Under 20					10.3
10-14					15.5
15-19					10.2
Minnesota	5.1				
10-14		10.0	11.1	14.0	9.4
15-17		7.9	7.6	9.1	8.7
18-19		7.6	6.7	7.4	6.5
Mississippi	8.8				
10-14		16.7	16.1	17.7	16.2
15-17		12.3	12.5	12.5	12.2
18-19		10.9	11.3	10.9	10.5
Missouri	6.7				
10-14		12.2	17.7	15.6	16.8
15-17		11.2	10.5	11.1	9.9
18-19		9.9	8.6	8.3	9.1

State and Age of Mother	Statewide LBW* 1/ (all age mothers) 1983	1978	1980	1982	1983
Montana	5.6				
10-14		20.0	7.1	0.0	7.1
15-17		9.0	9.7	8.5	8.7
18-19		7.7	7.1	7.0	6.9
Nebraska	5.4				
10-14		25.0	12.5	3.0	0.0
15-17		10.4	9.7	8.6	9.9
18-19		7.4	7.5	7.2	7.5
New Hampshire	5.1				
10-14			0.7		
15-17			3.0%		
18-19			5.0%		
New Jersey	7.2				
10-14		14.0	13.4	13.0	20.6
15-19		11.7	11.5	10.9	10.9
New Mexico	7.6				
10-14				9.0 (1981)	
15-17				9.6 (1981)	
18-19				9.2 (1981)	
North Carolina	7.8				
10-14		15.5	12.7	17.0	17.0
15-17		11.7	12.3	12.1	12.1
18-19		10.6	9.8	9.8	9.6
North Dakota	4.7				
10-14		11.1	0.0	16.7	0.0
15-17		7.3	8.8	5.9	9.2
18-19		6.6	5.1	5.0	5.5
Ohio	6.7				
10-14		15.5	15.9	16.6	12.3
15-19		10.0	9.3	9.2	9.7
Oklahoma	6.7				
10-14		13.6	13.8	15.0	8.1
15-17		9.2	9.3	8.9	9.4
18-19		8.8	8.1	8.4	7.9
Pennsylvania	6.7				
10-14		16.2	14.5	12.7	20.1
15-19		9.7	9.5	9.9	9.6

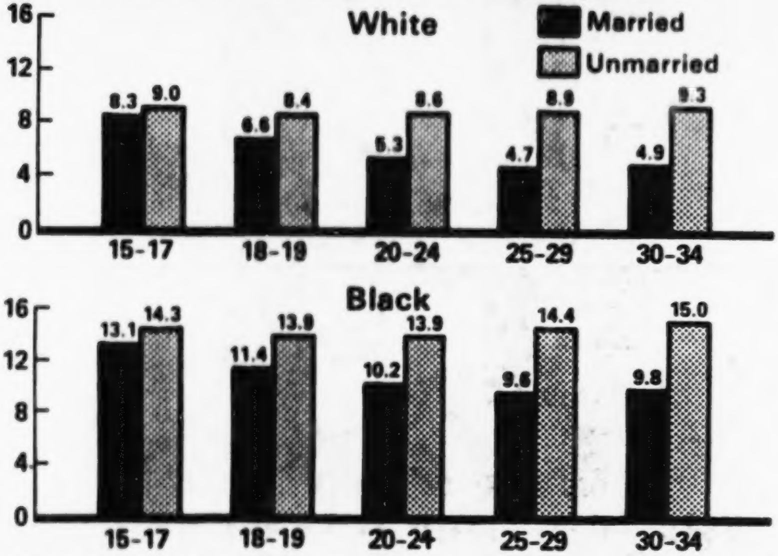
State and Age of Mother	Statewide LBW* 1/ (all age mothers) 1983	1978	1980	1982	1983
Rhode Island	6.4				
Under 14		11.8	16.7	9.1	11.1
15-17		8.6	7.8	10.0	11.5
18-19		9.0	8.5	7.2	9.5
South Carolina	8.6				
10-14		19.0	17.0	15.0	
15-19		12.0	12.0	13.0	
Tennessee	8.0				
10-14		15.0	13.7	13.4	12.9
15-17		11.4	11.3	11.7	11.2
18-19		10.2	10.1	10.1	10.1
Vermont	5.9				
10-14		22.0	25.0	20.0	14.0
15-17		10.0	11.0	8.0	5.0
18-19		8.0	6.0	7.0	6.0
Virginia	7.2				
10-14		16.0 (1979)	15.0	16.0	17.0
15-19		11.0 (1979)	11.0	10.0	10.0
Washington	5.2				
10-14		7.9	16.0	11.1	11.1
15-17			7.8	7.8	7.9
18-19			6.5	6.1	6.7
West Virginia	6.7				
10-14			9.3	8.5	12.7
15-19			8.5	7.8	8.4
Wisconsin	5.4				
10-14				16.5	
15-17				9.1	
10-17			9.1		
18-19			7.5	7.3	
Wyoming	7.1				
10-14		25.0	13.3	13.3	28.6
15-17			9.8	8.6	8.5
18-19			8.3	8.3	5.9
15-19		10.3			

1/ Births weighing under 2500 gm. as a percent of all live births in the state, in 1983.

*Source: NCHS, Monthly Vital Statistics Report, Advance Report of Final Mortality Statistics, 1983, Table 16, Vol. 34, No. 6 [Supple] 1985.

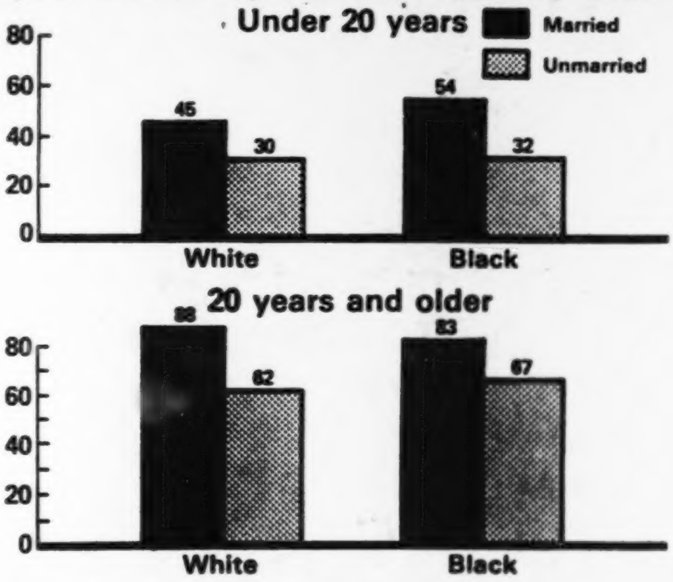
Figure 3

Percent low birth weight, by age and marital status of mother, 1982



SOURCE: NCHS, Division of Vital Statistics (69)

Figure 4

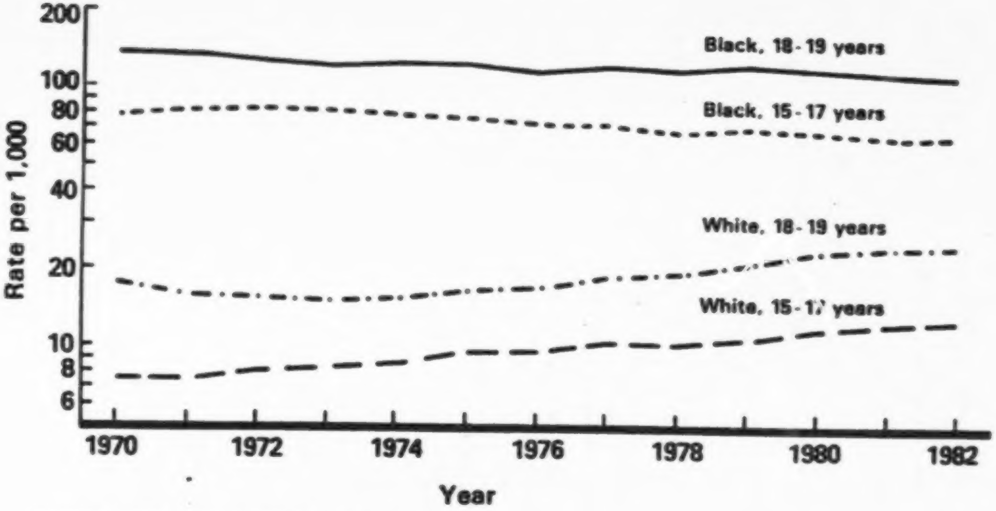


Percent of mothers who are high school graduates by marital status, 1982

SQURCE: NCHS, Division of Vital Statistics (69)

Figure 5

Birth rates for unmarried women aged 15-17 and 18-19, 1970-82



SOURCE: NCHS, Division of Vital Statistics (69)

CHAPTER II: BARRIERS TO SERVING AT-RISK, PREGNANT AND PARENTING TEENS

Nearly every State reported a serious teenage pregnancy and parenthood problem, and 26 specifically acknowledged that existing prevention and assistance services are inadequate to address the needs (Alabama, Arkansas, Arizona, Colorado, Delaware, Georgia, Hawaii, Indiana, Kentucky, Kansas, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, New Jersey, Ohio, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Virginia, Washington and Wyoming).

In contrast, California's survey response indicated that "the problem is not a lack of services, which are probably adequate in California; the problem is a social one...Young people need to have meaningful participation in their own families, school and community" (5). Wisconsin raised concern about even assessing the problems: "It is difficult to assess the adequacy of prevention and assistance services given the lack of data" (48).

In addition to an assessment of service adequacy, States identified many barriers to better service. As described by the States, these barriers fall into six categories: lack of education and public awareness, fragmented and noncomprehensive services, funding shortages, inadequate data, little prevention focus, and service gaps and inaccessible services.

STATES IDENTIFY NEED FOR MORE EDUCATION, PUBLIC AWARENESS AND COMMUNITY INVOLVEMENT

To promote the concept of prevention and improve assistance to pregnant and parenting teens, a total of 31 States emphasized a need for more educational opportunities, not only for pregnant and parenting teens, but for the entire community. Their comments generally fell into the sub-categories of community education, public awareness, or educational interventions in schools. The total of 31 reflects a combination of these three groups.

Examples of State Responses Regarding Education

Massachusetts

Pregnant students often drop out of school because of limited alternative school programs and a lack of support services. There are no mandated state-wide programs for this population. Although Massachusetts General Law Chapter 622, the State's Equal Education Opportunity Law, prohibits schools from excluding students on the basis of pregnancy status, the lack of school-based services often leads to de facto exclusion [21(a)].

Minnesota

We need more public information efforts, e.g., media efforts to present information and model communication relative to responsible sexual decisionmaking and behavior, as well as service use and availability (23).

New Hampshire

The key is education for both teenage boys and girls and the communities. The issues of growth and development, injury prevention, child abuse, jobs training, suicide, alcohol and drug abuse, self image are all outside of their reach in the world in which they grow up in. Successful programs that have addressed many of the most distressing problems are those located in the Jr. and Sr. High School. You must take these services to the kids. At this stage, fear of being different, lack of transportation and lack of family support all create a most trying time that often affects their future position in society.

The priorities should be to let each kid have an opportunity to develop both physically and emotionally within an environment that is educationally based. Provide teens the tools to make informed decisions based on fact and objectivity. To prevent unwanted pregnancy, to keep them in school and to reinforce their creativity will be the mark of successful state/federal initiative (29).

New Jersey

If we had funds to do education in the schools, in the community, in the workplace (corporate and the like), we could begin to make an impact before the problem arrives (such as teenage pregnancy, suicide, drug abuse, school drop-outs). We need funds to teach each other (Federal, State and Local Community at large) the basic skills of better communication with our children, teaching themselves respect and how to be responsible for their own behavior and the consequences involved. Above all we need funds to impact the media and the messages we all receive that affects our lives (our behavior and attitudes towards life) (30).

Texas

In the area of education, the alternatives for a pregnant teenager's schooling are limited and lack uniformity across districts [42(a)].

Washington

There is a need for more alternative educational programs for pregnant and parenting teens. The programs need to stress: (1) Completion of at least high school education and ideally provide for further education -- either skills training or college, (2) normal growth and development of the infants and children with implications for parenting and promotion of the health of these children, and (3) appropriate, growthful peer and social interaction skills (46).

Florida, Georgia, and Tennessee also stressed the important role of education in improving prevention services.

Seventeen States suggested strengthening family life education, sex education, and parenting education efforts (Connecticut, Georgia, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, North Carolina, North Dakota, South Carolina, Tennessee and Texas):

Indiana

The need for early intervention was endorsed by the results of a community survey which requested respondents to list the most critical needs for teenage mothers in our county. The most frequent response was parent education. Although 22 agencies were identified as providing some type of service for these mothers, teaching teens to be better parents remained the most critical need and the one that has not been effectively addressed [14(a)].

Kansas

Education programs on responsible parenthood and parenting skills need strengthening through public schools and public information programs (16).

Kentucky

We should see increased funding needed for programs in schools in the areas of family life living, human sexuality, and adolescent choices (17).

Massachusetts

Parenting and health education classes are unevenly available throughout the state [21(a)].

Minnesota

We need family life and sex education in all schools - with or without parental involvement (they certainly must be offered the opportunity and encouraged to participate, but not all will) (23).

New Jersey

Family life education is a policy for all public schools. However, there is a need for increased teacher training in this field and for more resources for the teachers so that this program can be enriched and strengthened (30).

Finally, nine States also suggested that it might be difficult, or even inappropriate, to institute programs targeted to adolescents without community and parental involvement (Alabama, Idaho, Maryland, Massachusetts, Michigan, New York, North Carolina, Washington, West Virginia). If such involvement is lacking, they noted, full implementation of services will be difficult. As Indiana reported, "there is need to recognise that adolescent pregnancy is a community-wide problem which requires community-wide support" (14).

West Virginia also acknowledged the importance of greater community involvement, and the need to "work with schools and parents" (47). Alabama noted that its State health department specifically "needs more money for community outreach and parental involvement activities that directly relate to services to teens" (1).

Maryland's Task Force on Teen Pregnancy recommended the development of a "community-based strategy in which community-based organizations are actively involved in the development and delivery of teen pregnancy prevention programs" [20(a)].

Washington found that the "imposition of [a] program in [the] community without local support," did not work (46).

STATES LACK COORDINATION AMONG EXISTING SERVICES

A majority of States (28) cited a lack of coordination among state and local cies as a serious problem. (Alabama, California, Colorado, Connecticut, Delaware, Georgia, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, and Wyoming).

A variety of approaches and services are required to prevent adolescent pregnancy and to address the multiple needs of pregnant and parenting teens and their children. However, even if adequate services are available, poor coordination among public and private delivery systems often prevents adolescents from receiving necessary information and services.

Two-thirds of the States which reported coordination problems have issued recommendations or taken steps to improve coordination.

Examples of State Responses Regarding Coordination of Services

Indiana

Statewide planning and coordination is needed to reach more adolescents with the comprehensive range of services they require (14).

Louisiana

There is currently fragmentation of the services needed by teens amongst many public and private agencies. Better coordination could focus effort and avoid duplication of efforts (18).

Maryland

The need for much stronger interagency public/private coordination, at both the state and local levels, was consistently identified as a major problem. Many services exist and are delivered by public and private agencies in such areas as health, education, income maintenance, social services and employment and training. However, these services are not linked, coordinated, or managed in any systematic way [20(a)].

Michigan

There currently is no coordinated state policy or position regarding government's role in teen pregnancy/teen parenting issues. Four major state departments have progams and/or funds directed toward services to pregnant and/or parenting teens. However, since most of the state departments operate through legally autonomous branch agencies, there is little coordination and integration amongst the departments in either service delivery or strategizing for combating the underlying causes of teen pregnancy [22(a)].

Montana

There is no statewide coordination for programs directed towards adolescents. Several agencies are involved in a variety of programs, but it is very difficult to determine the extent of involvement and overall statewide services (26).

New Jersey

Fragmented services are not highly useful to the teen population, especially if there is no transportation provided to link one service with another. Fragmented services also fragment the responsibility for services and detracts from the comprehensive approach needed (30).

Ohio

The various aspects of adolescent life are being addressed by a number of state agencies. Improved communication and interaction among the Departments of Health, Education, Human Services, Mental Retardation, et. al., is needed to facilitate definition of the problem, strategic planning for solutions, and implementation. Only in this way can gaps in services be identified and duplication of services avoided (36).

Washington

There is a lack of case management for coordination and follow up. There are piecemeal services, e.g., return teen to school and do not provide for child care; offer parenting education with no transportation (46).

Alabama, North Carolina, and Ohio suggested that, to improve coordination, a specific lead agency or coalition was required:

Alabama

We strongly believe that the overall effort in this area could be improved through the development of a central task force, committee or agency responsible for bringing together the diverse segments of the population who are interested in this problem. These are such groups as Education, Public Health, Public Welfare and other state agencies; private agencies such as the United Way, Salvation Army; special interest groups, such as PTA, League of Women Voters; client groups; church groups; legislators; and representatives from the Governor's office. Statewide coalitions can serve to coordinate existing services, study the problem and develop new coordination possibilities, advocate for the establishment of local coalitions, and lobby for policy or legislative initiatives, etc.

The formation of local coalitions made up of all interested groups are also helpful for developing the type of multi-faceted solutions that are necessary at the local level. Through the state or local coalition or through key agencies, the local coalition can be made aware of an array of successful approaches and they can develop a comprehensive program (by increment, if necessary) that is politically and economically feasible in their locality (1).

Ohio

There needs to be an identifiable body recognized by the public and private sectors as coordinating adolescent health issues. Numerous groups have contacted the Department of Health asking for participation in their effort toward reducing teen pregnancy. Many of these efforts are duplicative. Far more could be accomplished, and more efficiently so, if these enthusiastic individuals combined their efforts in problem solving (36).

> **North Carolina**
>
> North Carolina needs to designate a lead agency and provide adequate staff support to coordinate programs and policies relating to adolescent pregnancy and parenting (33).

One county in Indiana, particularly concerned about the rise in child abuse cases and research which indicates teens are at high risk of abuse or neglect of their children, conducted a community survey to determine the services available to teen mothers:

> **Indiana**
>
> The survey indicates that services that do exist appear to be scattered and inadequately coordinated. As a result, teenage mothers may receive brief services without adequate follow-up or referral to other appropriate programs. Most contact is provided on an individual basis rather than in a group setting with the exception of the school age mothers program and group nutrition classes at WIC. Therefore, teenage mothers do not have the opportunity to establish a supportive relationship with their peers that could be helpful as they learn to cope with the daily problems of mothering and also reduce the risk of abuse and neglect [14(a)].

STATES HAVE INSUFFICIENT FUNDS TO REACH TEENS IN NEED

For many States, lack of funds for services targeted specifically to adolescents and/or pregnant and parenting adolescents remains a barrier to progress. Nineteen States indicated that inadequate funding constitutes a barrier to comprehensive and effective programs to reach the numbers of teens in need. (Alabama, Arkansas, Georgia, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Maryland, Mississippi, Missouri, New Hampshire, North Carolina, North Dakota, Ohio, Tennessee, Washington, West Virginia and Wyoming).

Many comments focused on funding shortages within particular Federal programs (For further discussion of Federal funding, see Chapter III: Federal Policies and Programs, and State Efforts, and Tables 7 and 8). Four States (Indiana, Kansas, Mississippi and Wyoming) also noted the need for greater State funding, as well as greater State attention to their adolescent population.

Examples of State Responses Regarding Funds

Arkansas

> The Department of Human Services provides absolutely minimal assistance to pregnant and parenting adolescents. Funding for education, employment training, parenting training, and other support services needs to be greatly increased (4).

Georgia

> Education and programs for younger teens, males, and parents need to be expanded, but funding has not increased (10).

Kansas

> The existing preventive services are inadequate to meet the needs of adolescents in Kansas. The maternity and infant care projects have proven to be a good model; however, they currently reach only 750 of the 1,600 pregnant adolescents 18 and under each year and less than 10% of the 19 year olds. Funding for these community projects needs to be expanded from $458,000 to at least $2 million (16).

Massachusetts

> Special programs which have been designed to ameliorate the possible negative consequences of early childbearing are available for young mothers. These programs, while good, reach only a portion of teen mothers in need. The two programs combined serviced nearly 3500 teenage mothers in 1983 - about 13% of teenage mothers throughout the state. However, funding was not provided in these programs to make the essential services of day care or transportation adequately available [21(a)].

Mississippi

> With one of the highest rates of adolescent pregnancy in the nation, as well as a high rate of adolescents dropping out of school, combined with federal budget reductions, we do not have adequate resources to meet the needs of adolescents (24).

Missouri

There is a need for new and expanded programs in Missouri, particularly in the areas of education, counseling and treatment/preventive services for adolescents. Funding has been and continues to be limited, preventing aggressive approaches to this unmet need (25).

Tennessee

Existing services for adolescents are definitely not adequate. Agencies do not have the funds or staff to reach out and provide the social, educational, medical, and psychological services needed for adolescents (41).

STATES COLLECT INADEQUATE DATA TO DEVELOP EFFECTIVE PROGRAMS

Fifteen States indicated that inadequate data remain a barrier to improving services to at-risk, pregnant, and parenting teenagers (Alaska, Georgia, Delaware, Idaho, Illinois, Indiana, New Hampshire, New Mexico, New York, North Carolina, Ohio, South Carolina, Texas, Wisconsin, Wyoming).

States lack the ability, using current data, to fully assess the problem and design appropriate services. Five of these States (Arizona, Illinois, New York, North Carolina, and Texas) cited the need for evaluation data on successful prevention and intervention programs which might assist them in developing better strategies.

For those State services provided through the Federal Maternal and Child Health Block Grant or the Social Services Block Grant, there is no longer any requirement that States collect data on services being provided, expenditure levels, or the number receiving services. The Omnibus Budget Reconciliation Act of 1981 eliminated this requirement. Funding was cut back as well, leaving States without the resources to collect this information on their own.

Examples of State Responses Regarding Data

Alaska

Unfortunately, most of the information requested is unavailable to us in the form that you have requested. Many of the divisions of the state keep minimal statistics, and do not document services to adolescents and/or services to pregnant adolescents as a separate category. The department does not now have the resources to research this material [2(a)].

Ohio

As the response to this questionnaire demonstrates, sufficient data does (sic) not exist to define the problem. Statistics regarding adolescent health, education, employment, etc. are currently compiled by separate state agencies. Data collection and storage (to this point) has not been efficient enough to allow for easy retrieval and study of information. It is however recognized that the extent of the problem is large (35).

South Carolina

Agencies and organizations dealing with teens need to keep teenage-specific data...[The State now uses 14-17 year old female cohort data for calculating the teen pregnancy rate rather than data on females aged 15-19]...by using these data, the citizens of South Carolina will be better able to target their efforts of pregnancy prevention and will be better able to see the results of these efforts [39(c)].

Wisconsin

It is difficult to assess the adequacy of prevention and assistance services given the lack of data. Clearly, Wisconsin families and communities are doing something right since Wisconsin has a lower rate of teen pregnancy than the rest of the nation. However, we expect to have a better feel for how well we are doing in preventing teen pregnancies and serving teen-headed families as we begin directing services specifically to these purposes (48).

North Carolina

To date, there has not been a comprehensive survey of various approaches to serving adolescents in terms of examining the relative effectiveness of sufficient models. There is interest, however, in the result of nationwide studies such as that conducted by the Center for Population Options. This particular study has shown for example, that school-based preventive services when offered in conjunction with curricula on family life/sex education, appear to be a significant factor in reduction of teen pregnancy rates (33).

Illinois

Illinois has made a major commitment to adolescent pregnancy prevention with the $12 million allocated to the Parents Too Soon program. A variety of prevention programs have been

> funded. What is needed at this point in time is an in-depth look at which program models will produce the best results. Armed with data to indicate the success of these models, additional funding for replication will be more easily obtained from the public and private sector (13).

Arizona

> With the increased attention on this issue, it is imperative that the services be monitored and evaluated to determine what really works. Do parenting programs work? Do support groups work? Why do some adolescents on birth control get pregnant? What emotional factors affect teenage pregnancy? These questions need to be answered so that new programs can be developed and implemented (3).

STATES SEEK MORE EMPHASIS ON PREVENTIVE SERVICES

Eleven States noted that there has been too little focus on prevention, as opposed to intervention services, for pregnant and parenting teens. (Georgia, Illinois, Maryland, Michigan, New Jersey, New York, North Carolina, North Dakota, Texas, Washington, and Wyoming). The majority of specific programs listed by States also most often target already pregnant and parenting adolescents, rather than all adolescents.

Prevention emphasizes reducing adolescent pregnancy and parenting by reaching teenagers with appropriate education and services before they become pregnant. Many professionals use "primary prevention" to refer to the prevention of a first pregnancy, and "secondary prevention" to refer to assisting already pregnant or parenting teens from having another unwanted pregnancy. A variety of services and programs are viewed as direct or indirect preventive measures (e.g., sex education, family life education, abstinence education, family planning, teen counseling services, general health services for adolescents, school dropout prevention programs, parent education programs, and mass media campaigns). Improved health services, particularly in secondary schools, may also serve to prevent teen pregnancy and parenting.

Examples of State Responses Regarding Prevention

Michigan

Most existing services are remedial rather than preventive; i.e., they are directed toward the teen girl after she has become pregnant and decided to have and parent the child [22(a)].

New Jersey

Of all the monies allocated for servicing women and children (MCH, Family Planning, others) there are none specifically allocated for prevention or to assist in prevention of teenage (adolescent) pregnancy. Most funds are given to help in providing services after the fact (better medical care, care for those not taking advantage of what health services are available.) These services are needed but better utilization of these services can be made (30).

New York

As with all populations served by the human services systems, services for pregnant, parenting, and at-risk adolescents are constrained by limited resources. Within these restraints, the state has tended to serve those who are most in need (i.e., those in states of crisis or those least able to cope). As a result, effective primary prevention strategies to reduce the incidence of pregnancy in adolescents have often been diverted by the very real need to address the daily problems of those who are already pregnant and parenting. The New York Task Force believes that this reactive strategy to the issue of adolescent pregnancy has perpetuated and will continue to perpetuate the current situation [32(d)].

North Carolina

Too little is being provided too late for primary prevention. A multi-faceted regimen of preventive educational and support services for families with children should be initiated far in advance of the time the children reach puberty. Services should be provided systematically with broad community support (33).

Texas

Nearly all of the agencies expressed a desire to see the state focus become more preventative in nature and less crisis-oriented. Numerous studies have suggested the long-term cost-effectiveness and cost-savings of such a preventive policy but resource limitations have limited the ability of State agencies to focus on prevention [42(a)].

Washington

Most funding is directed at costly crisis situations and terminal care rather than more cost-effective preventive measures (46).

STATES HAVE SUBSTANTIAL SERVICE GAPS AND INACCESSIBLE SERVICES

Eleven States cited one or more gaps in their efforts to assist at-risk, pregnant and parenting teens (Arkansas, California, Florida, Indiana, Kansas, Massachusetts, Minnesota, New Jersey, North Carolina, Pennsylvania and Texas). These areas include: child care, prenatal and perinatal care, housing, job training, adoption, and contraceptive services. Others cited the inaccessibility of current services as a significant barrier.

Examples of Gaps in Current Services

Arkansas

From a health care standpoint, future plans need to include the following: (1) Increased provision of contraceptive services at the onset of sexual activity; (2) increased and improved availability of primary, secondary, and tertiary perinatal care, emphasizing the onset of care during the first trimester (4).

California

In its 1982 Report to the Legislature, the Department of Health Services, Maternal and Child Health Branch, identifies a lack of health care as being of major significance in the higher risk status of pregnant adolescents. They have determined that teens may not have access to, or seek care available, because of: (1) ignorance of need for care and/or resources available; (2) lack of acceptance of available providers; (3) language or cultural barriers; (4) transportation problems. Further, they find that traditional prenatal care, even when received, may not address the special needs of these at-risk young women [5(b)].

Indiana

Services to youth in regard to employment and training is inadequate. JTPA is not structured to address the financial support and personal counseling needs that may be more immediate or require resolution before employment training can be effective.

A broad range of services including clinical services, family life/sex education, parenting, infant stimulation, counseling, employment and vocational services, support etc. is needed to effectively address the problems of teen pregnancy and parenting. In addition, coordination of these services is essential if any are to enjoy success. Currently, Indiana has some programs and services in all of these areas, but they represent a "drop in the bucket" compared to the need (14).

Massachusetts

The essential and timely comprehensive prenatal and postpartum care which pregnant and parenting adolescents and their children need is not universally available or accessible to them... because of limited funding, regulatory or policy barriers (Medicaid), or availability problems (Medicaid and other health insurance plans). Lack of affordable housing which affects most low-income families also limits the availability of decent housing for teen parents. Because the education of teen mothers is often truncated, they are often ill-prepared to participate in employment training programs or to acquire employment. The available programs for job training for youth do not have adequate resources or priorities developed for basic skills remediation [21(a)].

New Jersey

The greatest need in services for the teen parents is for housing for the teen mother and the baby, for infant day care, for a comprehensive service/advocacy approach in relation to services, an increase of services for teen fathers or for male teens to prevent fatherhood (30).

North Carolina

The inadequacy of existing preventive health services is the major rationale for an expansion budget request currently under consideration. This request addresses the need for expanding preventive family planning services as well as prenatal care and payment for labor and delivery. The request also contains funding for community-based risk reduction projects focusing on adolescent pregnancy prevention (33).

Texas

Awareness of adoption as a viable alternative to teen parenthood is a problem in the teen population and further outreach efforts need to be developed in the state [42(a)].

Kansas also suggested that family planning and venereal disease programs were in need of additional support.

Florida, Kansas, Massachusetts, Minnesota, North Carolina and Texas emphasized that lack of subsidized child care is a particular barrier for teens in finding employment or attending school and that child care remains a major service gap.

> Massachusetts
>
> Parenting students require reliable and good child care for infants and toddlers which is of very limited availability. Neither the contracted day care program of DSS [Department of Social Services] nor the voucher day care program of the Department of Public Welfare is able to meet the child care needs of this population, essential for teen mothers to participate in academic or vocational programs. Furthermore transportation to and from the child care site is often unavailable [21(a)].
>
> Minnesota
>
> Resource and funding for child care are definite needs (23).
>
> North Carolina
>
> Subsidized child care to enable teenage parents to complete high school is inadequate (33).

Examples of Inaccessible Services

Eleven States also described the inaccessibility of current services as a barrier to serving adolescents (California, Georgia, Hawaii, Indiana, Maryland, Massachusetts, Minnesota, New Hampshire, Texas, West Virginia and Wyoming). Accessibility is affected by location of services, hours of service availability, as well as the manner in which services are provided.

> **Hawaii**
>
> Programs and services specifically targeted to sexually active, pregnant and parenting teens are few and limited to small geographic areas in the state (11).
>
> **Indiana**
>
> In urban areas there are some services but access is limited. In rural areas, services are practically non-existent and there are large barriers to the use of services (14).
>
> **Minnesota**
>
> Many rural areas have no family planning services at all -- we need this as a focus on adolescents (23).
>
> **Texas**
>
> Resources in the rural areas were repeatedly mentioned as the weakest component of the service system. The problem is exacerbated by the fact that there are usually no transportation services available to get the teens where there are services. There is one state sponsored transportation program which is partially funded through the Social Services Block Grant. However, in the last ten years the program funding has not grown to match the need or the increase in costs to provide the services. Pregnant teenagers and teen parents often do not have their own transportation and this diminishes their ability to access services. As long as clients cannot get to a facility where a program is offered they are unlikely to take advantage of it [42(a)].

Georgia also identified transportation and limited clinic hours as "barriers to accessing services" (10).

West Virginia reiterated, in relation to family planning services in particular, "access to family planning services for adolescents needs to be easier, with greater number of clinics offering weekend hours" (47).

In addition, Maryland and Massachusetts noted that program designs that are not sufficiently sensitive to adolescents can also impede the effectiveness of such efforts.

Maryland

The effective use of such services by pregnant or parenting teens demands that teens be reliable and keep appointments; that teens be planful and arrange for transportaton and child care, when appropriate; and, that teens be able to assess their needs and the needs of their infants to determine an appropriate course of action. Unfortunately, a significant proportion of teens are ill-equipped to meet those demands....Thus a core services system specifically developed to be sensitive and accessible to pregnant and parenting teens is essential to the effectiveness of any attack upon the teen pregnancy and parenting problem [20(a)].

Massachusetts

Non-targeted programs and services in education, employment training, day care, and basic human services present some serious barriers of access for pregnant and parenting youth. These barriers are embodied in some state-level policies and agency practice [21(a)].

For additional States' comments and recommendations, see Table 7.

CHAPTER III. FEDERAL POLICIES AND PROGRAMS, AND STATE EFFORTS

FEDERAL PROGRAMS UNDERGIRD STATE EFFORTS

Several Federal programs can serve adolescents, including pregnant and parenting adolescents. These include the Adolescent Family Life Program (Title XX of the Public Health Service Act), Adoption Assistance (Title IV-E of the Social Security Act), Aid to Families with Dependent Children (AFDC, Title IV-A of the Social Security Act), the Education Consolidation and Improvement Act (Chapter 1), Family Planning (Title X of the Public Health Service Act), Job Training Partnership Act (JTPA), Maternal and Child Health Block Grant (Title V of the Public Health Service Act), Medicaid (Title XIX of the Social Security Act), the Social Services Block Grant (Title XX of the Social Security Act), the Special Supplemental Food Program for Women, Infants and Children (WIC), and Carl D. Perkins Vocational Education Act.

A description of major Federal programs which address some aspect of teen pregnancy can be found in Appendix IV.

States Use Only Small Percent of Federal Funds for Adolescents

Thirty-two States report using Federal funds to serve adolescents and/or pregnant and parenting adolescents, and identified specific funding levels spent for such purposes from at least one Federal program. In almost every case, funds from the programs listed above which are spent on services for adolescents represent a very modest percent of overall funds available in that program.

Of the thirty-two States reporting specific funding levels, however, only fifteen identified Federal funding directed at pregnant and parenting adolescents as opposed to funds spent on other adolescents. Some States reported only single project grant awards from the Maternal and Child Health Block Grant or Adolescent Family Life grants. For many of the Federal programs, States did not report the number of adolescents being served (See Table 8: Federal Funding).

Only one Federal program has as its primary focus teenage pregnancy prevention -- the Adolescent Family Life Program. Since it began in 1981, however, only $15 million has been appropriated for any one year. For the most part, funds are available as categorical grants to local agencies.

Three States (Illinois, Georgia, and Massachusetts) reported using Federal Emergency Jobs Bill Supplemental Funds made available in 1983 to target pregnant and/or parenting adolescents.

APPLICATION OF FEDERAL SERVICES AND POLICIES VARIES ACROSS STATES

A state-by-state summary of State comments on Title V, Title X, Title XIX, Title XX Adolescent Family Life, WIC, AFDC, Title IV-E Adoption Assistance, and other programs can be found in Table 7, page 76.

Those comments, as well as related observations States have made, are summarized below.

Adolescent Family Life Projects

This grant program allows local agencies to provide prevention and care services for at-risk or pregnant and parenting teens. For a more complete history and description, see page Appendix IV.

Nineteen States were aware of at least one Adolescent Family Life Project currently funded by the Office of Adolescent Pregnancy in their state, even though there are currently sixty State or local projects in 42 States. (Alabama, Georgia, Hawaii, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, New Hampshire, Oklahoma, Rhode Island, Tennessee, Vermont, Virginia, Washington, Wisconsin, North Carolina). (See Appendix V for current list of grantees.)

Additional Adolescent Family Life Act-Related Comments

Ten States recommended modifications in the Adolescent Family Life Act [Iowa, Louisiana (local barriers to implementation), Maryland, Minnesota, New Hampshire (expand family education), New Jersey, North Carolina, Ohio, Virginia, Washington].

Adoption Assistance

Five States recommended increasing adoption opportunities, counseling and information for adolescents. (Massachusetts, New Hampshire, Oklahoma, Texas, Washington).

The Education Consolidation and Improvement Act (Chapter I)

Chapter I is the major Federal program which assists local school districts to provide compensatory education services to educationally disadvantaged and low-income students. For a more complete program history and description. See Appendix IV. Pennsylvania reported the total amount of ECIA Chapter I funds received for adolescents. Pennsylvania and Maryland reported the total number of adolescent students benefiting from Chapter I monies. Wisconsin is the only State that reported the total amount of ECIA Chapter II (Education Block Grant) funds received and spent on all adolescents, and those who are pregnant and parenting. States reported various school-based programs that use ECIA funds. Maryland, for example, has a school-based program that provides family life education and services, which is at least partially assisted with Chapter I funds.

Additional ECIA-Related Comments

Michigan recommended "that the Department of Education review, modify, or clarify policies and practices regarding access to Chapter 1 (reading problems) and Chapter 2 (unlimited use) funds for school-based programs for pregnant and parenting adolescents."

Family Planning

Most Family Planning (Title X) dollars are awarded to family planning clinics. Among the services which must be offered are services to adolescents. For a more complete program history and description, Appendix IV.

Nationally, an estimated 34% of those served under Title X are women under twenty.

Twenty-two States provided information on the number of adolescents served under Title X.

Eight States reported serving fewer adolescents in 1982 than in 1980 (Arizona, Florida, Iowa, Kentucky, New Jersey, Utah, Virginia, Washington).

Six States reported serving more adolescents in 1982 than in 1980 (Alabama, Arkansas, Kansas, Maryland, Montana, North Carolina], and several States served essentially the same number (Delaware, Georgia, Mississippi, North Dakota, Oklahoma). Louisiana served more adolescents in 1982 than in 1980, but only half the number who were served in 1978.

Three States reported spending more Title X funds, directed specifically to adolescents, in 1982 than in 1978 (Louisiana, Alabama, Kansas). Oklahoma spent more in 1982 than in 1980, but still less than in 1978. Kentucky doubled the amount spent on adolescents betweem 1978 and 1980, but did not report any information for 1982. North Carolina stopped directing Title X funds to adolescents in 1982. Georgia maintained the same level of funding in 1982 as in 1980.

Georgia, Kentucky, and Louisiana spent between 9% and 14% of their Title X funds specifically to serve adolescents in 1983, while Alabama allocated 36% and Kansas 26% for adolescent services.

Alabama, Wyoming, and Ohio recommended increased funding for Title X to serve adolescents. Minnesota recommended that Title X remain categorically funded, while Maine recommended that Title X be block granted with other preventive health programs.

Additional Family Planning-Related Comments

Ten States recommended increases in available and accessible family planning services in general (Georgia, Maryland, South Carolina, Arkansas, Kansas, North Carolina, West Virginia, Minnesota, Illinois, Wyoming).

Job Training Partnership Act (JTPA)

This Act authorizes job training programs for disadvantaged youth and adults, summer job programs, and the Job Corps. For a more complete history and description, see Appendix IV.

Eight States reported some information on adolescents receiving services under JTPA (Arizona, Delaware, Missouri, North Dakota, Oklahoma, Pennsylvania, Washington, Wisconsin). Of those States reporting information for more than one year, each reported decreases in the number of adolescents served between 1980 and 1982 (Delaware, Missouri, North Dakota, Oklahoma).

Additional Employment-Related Comments

Six States recommended increasing job training opportunities for at-risk, pregnant and parenting adolescents (Arkansas, Connecticut, Indiana, Maryland, Massachusetts and South Carolina).

Twelve States recommended increasing child care opportunities for parenting adolescents (Florida, Georgia, Indiana, Kansas, Maryland, Massachusetts, Minnesota, New Jersey, New York, North Carolina, Texas, Washington).

Maternal and Child Health Block Grant

The Maternal and Child Health Block Grant provides health services to mothers and infants, particularly those with low incomes or limited access to health services. For a more complete program history and description, see Appendix IV.

States have not been required to maintain data on services or targeted funding since Title V was incorporated into the Maternal and Child Health Block Grant under the Omnibus Budget Reconciliation Act of 1981. Nineteen States, however, were able to provide information on the number of adolescents served under Title V for at least one year, although the type of service provided was not usually indicated. Twelve States reported this information for more than one year.

Half of the eighteen States commenting on the Title V Program recommended that no cuts be made in Title V and that funds be increased to meet the special needs of adolescents (Alabama, Indiana, Iowa, Kansas, Maryland, Mississippi, Rhode Island, West Virginia, Wyoming).

Only three States (Delaware, Louisiana, North Carolina) reported serving fewer adolescents between 1980 and 1982.

Eight States reported increases in the number of adolescents served under Title V between 1980 and 1982 [Oklahoma, Alabama, Iowa, Kansas, Kentucky, Montana, New Hampshire (between 1981 and 1985), Pennsylvania]. Pennsylvania, however, served fewer adolescents in 1982 than in 1978. West Virginia reported increases in the number of adolescents served between 1978 and 1980, but no information for 1982.

Twelve States reported directing Title V funds to adolescents for at least one year, although only six States reported directing Title V funds to adolescents for more than one year (Kansas, Kentucky, Louisiana, Montana, Oklahoma, Pennsylvania). Funds to pay for adolescent maternity services in Pennsylvania increased slightly in 1980, but reverted back to 1978 levels in 1982. Louisiana directed considerably fewer dollars in 1982 than in 1980 to four adolescent pregnancy programs funded under Title V. Kansas, Kentucky and Oklahoma increased their funding levels between 1978 and 1982, while Montana decreased its funding during this time period.

Almost 30% of Pennsylvania's Title V maternity care funds are directed specifically to adolescents, and nearly 20% of Kansas' Title V (MIC project) budget is directed to adolescents, up from 13% in 1978.

Other States reporting funding levels spend, on the average, only about 7% of their Maternal and Child Health Title V budget on adolescents.

Additional Health-Related Comments

Nine States recommended increasing comprehensive health services or expanded prenatal or perinatal care services for pregnant teens and their children (Arkansas, Kansas, Maryland, Massachusetts, Michigan, North Carolina, Rhode Island, South Carolina, Washington).

Nine States reported recommendations for, or the current operation of, school-based adolescent health clinics among their programs (Connecticut, Delaware, Indiana, Maryland, Michigan, Minnesota, Mississippi, New Hampshire and South Carolina).

Medicaid

Medicaid is a federal-state matching program providing medical assistance for certain low-income persons who are aged, blind, disabled, or members of families with dependent children. For a more complete history and description see Appendix IV.

Eight States reported some information on adolescents served under Medicaid (Title XIX), though the type of service was not usually indicated (Delaware, Florida, Maine, New York, New Mexico, North Dakota, Texas, Washington). Delaware, Florida, New Mexico, and North Dakota supplied information for more than one year.

Florida and North Dakota served more adolescents under Title XIX in 1982 than in 1978, while Delaware served fewer. New Mexico served more adolescents in 1980 than in 1978, but experienced a decrease in 1982. In 1983, 12% of Delaware's Title XIX expenditures went for adolescent services, compared to 1.5% in Florida and 63.7% in North Dakota.

Additional Medicaid-Related Comments

Eleven States indicated that Medicaid eligibility is too restrictive or coverage is too limited to adequately serve adolescents (Louisiana, Massachusetts, Maryland, Minnesota, Mississippi, New Hampshire, North Dakota, Ohio, Oklahoma, Tennessee, Washington). For a further discussion of Medicaid eligibility, see Appendix IV and discussion later in this chapter.

The Special Supplemental Food Program for Women, Infants and Children (WIC)

This program provides nutrition supplements to pregnant and nursing mothers and infants who are determined to be at nutritional risk. For a more complete program history and description, see Appendix IV.

Even though not required by law to keep such information, eight States reported funding levels and/or a monthly average caseload of pregnant and parenting adolescents served by WIC, for at least one year (Indiana, Kansas, Kentucky, Michigan, Oklahoma, Pennsylvania, Tennessee, and Washington). The States reporting this information for more than one year indicated an increase in the number of pregnant and parenting adolescents served between 1978 and 1982 (Indiana, Kansas, Oklahoma, Washington).

Additional WIC Related Comments

Eight States commented favorably on the change in WIC regulations which raised the priority level of high-risk postpartum teens to third. Under previous regulations this group received the last priority for service (Delaware, Kansas, Louisiana, Nebraska, Pennsylvania, South Carolina, Virginia, Washington).

Five States commented negatively on cuts in WIC, indicating that funding is inadequate to maintain current caseloads (Alabama, Indiana, Louisiana, Mississippi, West Virginia).

Two States described as one of WIC's strongest points its emphasis on referring teens to other necessary health and social services (Maine, Montana).

Two States spoke of the need to specifically target WIC services to teens (New Hampshire, Washington).

Three States commented on the need to expand eligibility criteria (California, Iowa, North Dakota).

Carl D. Perkins Vocational Education Act

This Federal program, administered by State boards of vocational education, local school districts, and area vocational schools, authorizes various vocational education activities and programs. Pregnant and parenting teenagers may benefit from this money if they are in need of consumer and homemaker education, or employment or career preparation. For a more complete history and description, see Appendix IV.

Although no States reported the total amount of vocational education funds received, three States mentioned school-based programs that use vocational education funds. Michigan has allocated $492,039 of vocational education funds, for use in FY 1986, for 12 school district projects for single parents. One regional high school in Pennsylvania uses vocational education money to support a school-age parent program which also provides infant and child care. Washington reported numerous school-based programs using, in part, vocational education funds. These programs provide many services for adolescents, including vocational home and family life education, and child care.

Additional Vocational Education-Related Comments

Maryland stated that the "Carl D. Perkins Act, effective July 1985, created additional funding for vocational education for pregnant and parenting teenagers" (20).

Massachusetts noted that:

> There is clearly a need for basic vocational services, such as, assessment, guidance counseling, basic skills education, vocational preparation, job skills training, work experience, access to job placement programs and actual jobs. The availability of guidance counseling must be increased in every school district throughout the Commonwealth, and should begin in the middle school years. One course of funding could be under Title II, Part B, of the Federal Vocational Education Act. Opportunities for females to participate in all vocational training should be expanded by using funds from the Federal Voctional Education Act (Title II, Part A) to reverse the documented sex segregation in vocational education programs [21(a)].

PARENTAL INVOLVEMENT CENTRAL TO ALL PROGRAMS

Thirty States responded, in various ways, to the issue of parental and family involvement, often in the context of sex education and family planning. (Alabama, Arkansas, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Mexico, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia). In many cases they made special reference to parental involvement as it applies to the Federal Title X program.[5]

Parental Involvement

Thirteen States indicated they have taken steps to encourage parental involvement in a range of programs. (Alabama, Arkansas, Florida, Georgia, Maryland, Mississippi, Montana, New Hampshire, New Mexico, New Jersey, North Carolina, North Dakota and Tennessee).

Parental Notification/Consent

Twenty-one States commented on parental consent policies as they apply to adolescents who receive educational services, counseling, and medical services related to contraception and abortion.

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[5] The Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, amended Title X of the Public Health Service Act to encourage, if practical, parental involvement when family planning services are provided to minor children. Pursuant to this provision, the Department of Health and Human Services, in February 1982, proposed regulations to require Title X projects to notify the parents of unemancipated minors when prescription drugs or devices are provided to these adolescents by family planning clinics. Final regulations were issued on January 26, 1983. They were scheduled to go into effect February 28, 1983. On March 2, 1983, a U.S. District Court judge in the District of Columbia issued a permanent injunction forbidding the government from implementing this rule. The decision was upheld on appeal (68).

(Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Virginia, Washington, and West Virginia).

Florida, Indiana, Minnesota, North Dakota, Oklahoma, Pennsylvania, Virginia, and West Virginia indicated that they require parental notification/consent for family planning and/or for abortion services. Indiana, Minnesota, Pennsylvania, and West Virginia reported that their policies reflected recent changes. Louisiana reported a recent change requiring parental involvement and consent necessary for the establishment of, and student participation in, sex education programs in schools. Rhode Island and Utah also reported a recent policy change, but no description of the changes was provided.

Connecticut, Georgia, Maryland, Michigan, South Carolina, and Washington noted that, under current or proposed State policies, adolescents at a specified age can consent to services without parental consent. Kansas reported that "the Federal mandate calls for services without restriction," but that "some local grantees require parental consent for minors" (16).

Eight States, half of which require parental notification for centain services, also expressed various concerns about the efficacy of notification and consent policies. Florida, Illinois, Maine and Minnesota recommend against restrictive parental notification and consent policies. Similarly, the Texas Legislature's Select Committee on Teen Pregnancy recommended that "all state-sponsored services be provided in an accessible and confidential manner" [42(a)]. Louisiana commented that its sex education policy "makes it difficult to improve services in the public school system" (18). Virginia also noted that its "parental consent requirements prevent many experienced, broad-based program providers from participating." And, Pennsylvania commented that:

> Although Pennsylvania does not receive any Title X funds, Title X changes have affected state-funded services because both the State and Title X fund the same provider network. Clients do not differentiate between the federally funded and the state-funded programs. This became very apparent when the 'squeal rule' was proposed under Title X in 1982. The number of teens coming to clinics for services remained the same as in 1983, although these numbers had increased by 11% for 1981 and 61% for 1982 (37).

RECENT CHANGES IN FEDERAL POLICY HAVE AFFECTED THE STATES' ABILITY TO SERVE THE AT-RISK ADOLESCENT POPULATION

AFDC Changes Undermine Support for Low-Income Teen Parents in Some States.

AFDC provides cash grants to children who lack support because at least one parent is dead, disabled, absent or unemployed. For a more complete history and description, see Appendix IV.

In 1984, changes were made in AFDC which directly affect the number of pregnant and parenting adolescents who can be served and the types of services they can receive. (Deficit Reduction Act of 1984, P.L. 98-369)

The Deficit Reduction Act (DEFRA) strengthened many AFDC provisions. However, one critical change has significantly reduced the number of teenagers who might be eligible. That is, the number of people whose income must be counted in determining a family's eligibility and benefit level was expanded to include minor siblings and grandparents. Income from grandparents, if the grandparents and the minor parent reside in the grandparents home, must now be counted, even if this income is not available to support the family. (66)

States were asked to respond to the question "Have recent changes in Aid to Families with Dependent Children (AFDC) and Child Health Assurance Program (CHAP) incorporated in the Deficit Reduction Act of 1984, affected your ability to provide services to pregnant and parenting adolescents? If so, please comment."

Seven States responded that these changes had little or no effect (Indiana, Iowa, New Hampshire, Kansas, Montana, Virginia, Washington).

Eleven States commented in more detail about this recent change (Arizona, Delaware, Florida, Louisiana, Maryland, Mississippi, Missouri, North Carolina, New Hampshire, Tennessee and Wyoming). Six States criticized the change (Florida, Louisiana, Maryland, Mississippi, North Carolina and Wyoming).

> Arizona:
>
> We anticipate a reduction in the number of pregnant and parenting teens eligible for AFDC due to requirements that require inclusion of income and resources from relatives with which the teen resides (3).
>
> Louisiana
>
> This provision should be repealed because it serves as a potential destructive policy that fosters breakdown of families and minor parents (18).
>
> Maryland
>
> Including the income of non-needy relatives of the minor mother will result in ineligibility for her child. Under

> these circumstances, a minor mother would have to live separately from her parents to qualify for any assistance for her child (20).

Mississippi

> The policy on pregnant teen income needs to change so they can be eligible for AFDC on their own income, not parents (24).

Missouri

> As a consequence (of these changes), many pregnant minors living with their parents are no longer eligible for AFDC or Title XIX (Medicaid) (25).

North Carolina

> ... this sometimes resulted in heightened tensions as parents resented being expected to become primary provider to grandchildren. Perhaps worse, from the child's point of view, the minor mother would move out of home to retain eligibility. Loss of day-to-day emotional support from family makes coping with the varied problems associated with adolescent parenting even more difficult for the mother and the child (33).

Tennessee

> The total effect of DEFRA has been a reduction in the AFDC program. Parenting adolescents living with their families have been affected although we do not have data on the specific effects of this group (41).

Three States (Delaware, Maryland and North Carolina) reported the number of cases which actually closed, or were expected to close, due to the AFDC changes imposed by DEFRA.

Delaware

> 134 Medicaid cases were closed because of the change in the law which requires income from a minor's parent's parents and siblings to be counted [8(a)].

North Carolina

> 369 cases were terminated or experienced a reduction in benefits due to the deemed income of a parent of a minor mother. The total monthly loss of benefits to this group was $69,222 during the first four months of DEFRA (33).

Maryland

> If minor mothers become ineligible, as it is expected they will be by application of this policy, 436 cases will be

> closed, and about 25 applicants per month would be ineligible [for AFDC] (20).

New Hampshire expressed a differing view: "The changes have had little effect. It has helped some - hurt others. The key is in providing not just increased financial support -- but an educational system that will stop the cycle of poverty and dependence these families and children live with day to day."

In addition, because Medicaid eligibility is linked to AFDC, with this change many teens could lose Medicaid coverage as well. The Health Care Financing Administration has ruled that AFDC changes will apply to Medicaid eligibility.

Additional AFDC Comments

West Virginia noted that "additional restrictive AFDC policies have made it more difficult to serve adolescents" (47). Pennsylvania, Maryland and Mississippi suggested that there should be more flexibility in eligibity or age criteria for serving teen parents.

Arizona, Indiana, New Hampshire and North Carolina also commented that services, such as parenting classes, child care, employment training and/ training of AFDC providers, should be expanded or improved through AFDC.

Medicaid Changes Enhance Preventive Health Services for Teen Mothers and Their Infants

DEFRA also required states, as of October 1, 1984, to extend Medicaid coverage to certain categories of pregnant women and children whose coverage was previously provided at the State's option. This provision is known as the Child Health Assurance Program (CHAP). These categories include persons meeting AFDC income and resources requirements if they are 1) first-time pregnant women, eligible from the time of medical verification of pregnancy; 2) pregnant women in two-parent families where the principal breadwinner is unemployed from the point of the medical verification of pregnancy; and 3) children born on or after Oct. 1, 1983, up to age 5, in two-parent families.

Of those States responding to the question of whether or not recent changes in federal policy have affected their ability to provide services to pregnant and parenting adolescents, most responded favorably with regard to CHAP. Alabama noted that CHAP had not yet been initiated in that State. Some responses were:

> Arkansas
>
> The CHAP provisions allow states greater flexibility in providing Medicaid benefits to pregnant women and new born children (4).
>
> Delaware
>
> Pregnant women will have Medicaid coverage for prenatal care earlier in their pregnancies. CHAP will allow the caseload to increase by 368 first-time pregnant women and 900 pregnant women in two-parent families [8(a)].
>
> Maryland
>
> We are encouraged by the expansion of CHAP guidelines which allow agencies to target child health services (via EPSDT) for pregnant and parenting teens as well as those at high risk of teen pregnancy (as in the school-based EPSDT programs recently intitiated in Baltimore City) (20).

North Carolina

The new legislation expanding coverage to include two-parent families and pregnant women has allowed us to provide services to more pregnant and parenting adolescents (33).

TABLE 7. STATE-BY-STATE COMMENTS REGARDING SELECTED FEDERAL, STATE AND LOCAL PROGRAMS

Survey Question #12: Please specify any policy or legislative recommendations to improve the delivery of prevention or assistance services to pregnant and parenting adolescents and other teenagers. Are there specific problems or strengths in any of the programs or policies listed below? Please specify other federal, state, and local programs for which you have recommendations.

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
Alabama	One strength of this program is the regionalized perinatal system. Inadequate funding remains a problem.	One strength of this program is that it is made available in every county health department. Inadequate funding remains a problem.		
Arkansas			A cap on these Federal Title XIX expenditures would limit Arkansas' ability to expand coverage to pregnant women, including adolescents.	
California	The Department of Health provides support services for pregnant and parenting teens through the Adolescent Pregnant and Parenting Programs which are MCH-funded, encourages greater coordination between the State Departments of Social Services, Mental Health, Developmental Services, and Education. Minimum standards for the organization and delivery of services to pregnant and parenting adolescents should be established.			

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
CA (con't)	Interagency agreements should be utilized to maximize current resources.			
Delaware	The Office of Adolescent Health, (a division of Public Health) will be working on school-based projects and developing specific procedures for public health clinics.			
Florida				While there is no specific policy for adolescents in need of child care, a child at risk of being abused would be given first priority for child care services.
Georgia		Teens are a special target population for Title X programs and comprise 1/3 of the population served. Teens seeking services are considered emancipated minors, and are offered a full range of services without parental notification or consent, which is perceived as a major barrier to services. Parental involvement is encouraged.		

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
Illinois		To maintain effective services to adolescents, parental consent laws must not be passed. To assure services reach those who need them, Title X coverage could be extended to 200% of the poverty level.		
Indiana	Unless additional funds are provided, programs for adolescents will only scratch the surface.			
Iowa	Sufficient federal and/or state funds are required to provide services statewide.	Given the Federal allocation methodology, funds are not available for counseling adolescents or for community prevention programs.	Same as Title X	Same as Title X
Kansas	Additional Federal funding of Title V is needed for program expansion. A strength of the current MCH program is that it promotes the integration of services for adolescents among schools, Medicaid and Title X providers and private resources.	The Federal mandate calls for services without restriction. Some local grantees require parental consent for minors.		

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
Kentucky			The Department of Social Insurance provides Title XIX Medicaid coverage to pregnant women, including adolescents, who meet the eligibility criteria of the Medicaid program, and there are no current plans for legislative recommendations to improve the delivery of prevention or assistance services to adolescents.	Title XX does not have a pregnant teen program. Therefore, there are not any policy issues.
Louisiana	As a result of the 1981 Block Grant, an adolescent pregnancy program is no longer required.	This program is generally helpful in providing services to teens.	Restrictive eligibility is a concern.	Restrictive eligibility is a concern.
Maine		Title X should be incorporated into the Preventive Health or MCH Block grant. The "Squeal" bill should not be enacted.	The proposed Medicaid cap would have a disastrous impact on the availability and quality of health care.	
Maryland	There is no perceived need to change this program, which provides perinatal services to pregnant women and their offspring.		There is a critical need to maintain health care services for teens and their children.	Funds have been programmed for basic services, although cuts since 1980 have been so severe that these services have been cut, and innovative approaches completely dropped from consideration. This is no longer an open-ended resource and should not be perceived as such.

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
Minnesota	Family Planning is no longer mandated, and 6% could be reduced, resulting in fewer services.	Since this is the only categorical program for family planning, it must be maintained.	The income of parents should not be considered in determining eligibility for 18-21-year-olds.	
Mississippi	Funds should be provided to assign public health nurses to provide nursing care and family life education in schools. Block Grant funds ($7.2 million) should be increased.		The State Welfare Board should increase the Standard of Need so that more teens are eligible for Medicaid.	A strength of this program is that non-Medicaid-eligible teens can receive free family planning services at County Health Departments.
Missouri				It is no longer required to expend these funds for services to pregnant or parenting adolescents. However, funds may be used to help prevent child abuse or neglect, and would cover parenting adolescents.
Montana	Better school programs are needed regarding pregnancy, parenting, etc.	A strength of this program is that it encourages family involvement, abstinence, sexuality education in communities, and referrals for positive pregnancy tests.		
New Hampshire	Legislation should be more specifically directed toward the teenage population. Funds for school-based programs are critical.	This program is being used to promote education in schools, centering on education for male teenagers.	Funds for covering the cost of teenagers who become pregnant should be increased.	Male involvement programs should be promoted.

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
New Jersey		A strength of this program is that the legislation requires that services be provided "without regard to national origin, handicapping conditions, age, sex, number of pregnancies or marital status." Although this legislation states that "counselors should encourage young clients to discuss their needs with parents or other family members," because it also mandates that "adolescents must be assured that the sessions are confidential and that any necessary follow up will assure the privacy of the individual," this is difficult to accomplish.	Same as Title X	Same as Title X
North Carolina		A major strength of this program is the focus on patient as well as community education. With this framework, educational efforts can be directed to both parents and teens, and to both postponing sexual involvement and to providing services to sexually active teens seeking medically related contraceptive care.		

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
North Dakota		Family Planning counseling and education will be available upon request to adolescents 17 years of age or younger on a drop-in or appointment basis. After a counseling/education session and before medical or contraceptive services are provided, a parent's or guardian's consent must be obtained.	Coverage should be provided for prenatal care in the first trimester.	Additional funding for local staff is needed.
Ohio		Program funds should be distributed on the basis of need. Currently, Ohio receives 14% of the available funds, but has 19% of the estimated need.	The current level of reimbursement is far from adequate. Title XIX should reimburse at 100% of the cost of providing services. There are also some problems in moving Title XIX recipients into HMO's, raising concerns that the quality of family planning services will decrease and it will be difficult to maintain confidentiality. Also, a less restrictive policy on funding abortions is needed.	Decisions regarding county funds are made locally, so a mandate would be required to assure that a portion of money is available for adolescent health care in each county. In some counties there is no requirement that funds be allocated for family planning and so they are not. In others, income verification is required and confidentiality cannot be assured, so many agencies opt not to use these funds.
Oklahoma	Oklahoma law currently prohibits the provision of family planning services to adolescents without parental consent.		Title XIX regulations should allow medical services for teenagers based on criteria other than the recipients' participation in cash assistance programs, which is the current policy.	

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
Pennsylvania	Pennsylvania's Maternity Program, as of January 1, 1985, provides maternity services contractors with incentive funding for the enrollment of pregnant adolescents 17 years old or younger.	Although Pennsylvania does not receive any Title X funds, Title X changes have affected State-funded services because both the state and Title X fund the same provider network. Clients do not differentiate between the federally-funded and the State-funded programs. This became very apparent when the "squeal rule" was proposed under Title X in 1982. The number of teens coming to clinics for services remained the same as in 1983, although these numbers had increased by 11% for 1981 and 61% for 1982.	A statewide system of family planning clinics (with Title V, XX and X), has eliminted duplicated services and increased access. The copayment exemptions for pregnancy care, pharmacy items for pregnant women, including adolescents, and family planning services, have been reasonable and helpful in the delivery of health care. The State Medicaid program has also increased fees for physicians' services, to help make these services for pregnancy-related care more available in rural areas.	Universal eligibility for women under 18 years, since 1978, has led to a marked increase in the adolescent caseloads of family planning clinics.
Rhode Island	Increased support is needed for comprehensive adolescent health services.	Support for comprehensive adolescent health services should be expanded.		
South Carolina		Under the "minors" law family planning services can be provided to a minor under 16 without parental consent.		

STATE	TITLE V - MCH	TITLE X - FAMILY PLANNING	TITLE XIX - MEDICAID	TITLE XX - SOCIAL SERVICES
Tennessee			One strength has been the additional Medicaid coverage provided for prenatal care services for intact families.	One strength has been that parenting and placement services have been provided. There is a need for programming to help adolescents achieve independent living, when appropriate.
Virginia		Availability of services is not restricted because of parental income or involvement requirements.	Same as Title X	Same as Title x
Washington	Preventive adolescent and pregnancy services should become a core requirement of the Block Grant, and include management, child care, education, and other support systems.	In providing family planning services, it should be assumed that all potentially and sexually active persons are knowledgeable and can be responsible for decision-making regarding contraception.	This program should help assure that all women are eligible for comprehensive prenatal services.	Services for the prevention of child abuse, as well as early intervention for victims, should be increased to enhance the development of healthy sexual attitudes and habits.
West Virginia	Increased funding and greater accessibility to schools are needed. More emphasis should be placed on preventive health care.			The cap on Title XX has prevented program expansion.
Wyoming	Additional funds are needed.	Since clinic sites in Wyoming are often inaccessible, more funds are needed to assure coverage. Additional State involvement would also help.		Unless higher funding levels are made available, prevention services will be limited and all available funds will be spent on placement.

TABLE 7. STATE-BY-STATE COMMENTS REGARDING SELECTED FEDERAL, STATE AND LOCAL PROGRAMS

Survey Question #12: Please specify any policy or legislative recommendations to improve the delivery of prevention or assistance services to pregnant and parenting adolescents and other teenagers. Are there specific problems or strengths in any of the programs or policies listed below? Please specify other federal, state, and local programs for which you have recommendations.

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State or Local Programs
Alabama		Possible cuts could reduce caseloads. Currently serving approximately 59% of potentially eligible at 150% of poverty.			
Arkansas			Administration's proposal to eliminate WIN and substitute a job search requirement at one-half current WIN funding is illogical. We should be spending for employment training and other activities should be increased to avoid long-term welfare costs, especially for adolescents.		
California		Federal policy should be revised to allow consideration of pregnant women as a family of two for income determination.			

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State, or Local Programs
Delaware		Pregnant teens are the top priority; high-risk postpartum teens are third priority.	Some incentive for participation in AFDC should be explored, such as conditioning the receipt of welfare.		The State should explore methods of cooperation among schools, the children's departments, economic services, public health and labor departments.
Florida			Changes as a result of the Deficit Reduction Act are more restrictive than prior requirements.	There is no specific policy relating to adoption assistance for pregnant teenagers.	State law imposes limitations on services to minors (i.e., parental consent is required unless the minors' physical and mental health is jeopardized). These limitations should be removed.
Georgia		WIC providers receive instruction by State nutrition staff in the special nutritional needs of adolescent mothers and in effective counseling strategies.			Under the Daisy program, all youth-serving agencies in one 12-county health district will be combined to improve access and coordination of services.
Indiana		Increased funding is necessary to provide WIC to all those eligible. The coordination of food, education, and health care referrals has had a positive impact on health of infants.	Mothers not working should be required to attend parenting classes funded through either child welfare or mental health, and child care should be provided. WIN should be expanded.		Funds should be increased for job training and preparation. A strength of JTPA is that through incentive grants youths with substantial problems can be served. (1) Expanding Department of Education initiatives to

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State, or Local Programs
IN (con't)					serve every community would be the most effective approach to teen pregnancy. Living skills courses are needed in junior and senior high schools. (2) There is a need for state funds to help take ownership for teen pregnancy and parenting programs and one specified agency should be asked to assume lead responsibility for these issues. (3) There is a great need for safe, economical day care, as obtaining/maintaining employment is very difficult for a teen mother with no access to child care.
Iowa	Increase the funds and availability to help "network" existent services.	Nutrition counseling is only available to pregnant or nursing mothers and small children. Nonpregnant adolescents are not eligible.			

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State, or Local Programs
Kansas	One project was initiated in 1982 in Emporia with a strong prevention component.	Pregnant adolescents have always had highest priority. Recent regulatory changes will also allow services for postpartum adolescents at a higher priority level. This option is a positive change which allows health services to maintain contact with the adolescents.			Additional state funding of adolescent programs is needed. At present more KDHE services are funded by federal, local, or private funds.
Kentucky			All recipients are Medicaid-eligible. Therefore, any pregnant adolescent already receiving AFDC is also provided with the full range of Medicaid services.	Title IV-E does not have a pregnant teen program. Therefore, there are not any policy issues.	
Louisiana	Act 480 of 1979: Local Option Sex Education requires local schools to implement the Act and to request assistance in establishing sex education programs. These policies make it difficult to implement services within	Decreased funds lead to decreased services to postpartum adolescents and others. Teen postpartum care has been raised from priority 6 to 3 but should be higher.			Abortion reporting forms no longer provide parish or residence information.

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State, or Local Programs
LA (con't)	the public school system. The majority of school boards have avoided a decision on the implementation of sex education.				
Maine		A strength of WIC is its commitment to assist pregnant and parenting teens not only with nutritious foods, but also with referral to other needed services.			
Maryland	AFL is too narrowly focused. Cutting State agencies out of funding loop has contributed significantly to the fragmentation of services and the lack of coordination among agencies.		The "minor mother" provision of The Deficit Reduction Act should be revoked, and AFDC for students from 18-21 and unborn children be restored. Innovative funding formulae (financial incentives) should be provided to serve at-risk pregnant teens in AFDC households.		The Maternity plan should be extended to assure payment for Diagnostic and Perinatal Assessment (including delivery), for indigent, high-risk mothers.

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State, or Local Programs
Minnesota	Parental notification for family planning should be removed.	Pregnant and lactating adolescents and their infants have a very high level of nutritional risk. Therefore, they have a high priorty for WIC services and receive benefits even when funding is inadequate to serve other groups.			
Miss.		The appropriation for WIC is insufficient.	Pregnant teens should be certified on their own incomes.		There is a need for sufficient funding from the State legislature to address the health care needs of indigent, pregnant patients.
Montana		A strength of WIC is access to the health care system.			
Nebraska		WIC regulations have been changed so that a higher priority is assigned to postpartum teens.			

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State, or Local Programs
New Hampshire	Family education needs to be expanded concerning the issues facing teens.	There is a need for national direction and a requirement under WIC to provide information and referral to pregnant teens and to improve the data collection system.	AFDC providers should receive additional education about existing prevention services in public health and other State agencies.	More public information to teens should be provided.	An adolescent health unit needs to be established to coordinate and establish appropriate programs. There is a need to raise the level of awareness of State leaders that services to teens will provide longer-term benefits in productivity. There is also need to establish a teen component to all social service programs.
New Jersey	This program does not address the interrelated social, health, and welfare needs of adolescents, particularly in low-income areas.				There is increased need for coordination at the State agency level for all services for adolescents, particularly those who are pregnant, parents, or at risk of becoming such. Funding is needed for a special office for this purpose. The following have emerged as the greatest needs for this population: (a) housing for the teen mother and child from prebirth up to 2 years post partum; emergency housing; short-term housing;

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State or Local Programs
NJ (con't)					independent living services; foster care; (b) infant day care; (c) single parent/teen parent increased public assistance; (e) improved services offered at public schools.
North Carolina	Coordination of the Adolescent Family Life Program with the Title X family planning program should be increased. Both programs share goals relating to meaningful parent involvement and concern about early prevention through encouraging abstinence.		IV-A funding should be allowed for child care to enable adolescent parents receiving AFDC to complete their high school educations.		The Federal government should speed approval by the FDA of NORPLANT (the 5-year birth control implant) and conduct more research into male contraceptives. At the State level, funding for school health coordinators has been critically important in supporting the incorporation of family life/sex education into public school curricula. Additional funding is needed to expand availability of this resource. Also, appropriate family life education should be required as part of core curricula, K-12.

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State, or Local Programs
North Dakota		WIC regulations [7CFR Part 246.7(c)] require that the entire household income be used when determining eligibility. This often restricts the eligibility of pregnant or parenting adolescents living with parents or other family members because of family and income.		Program is excellent, cost effective, and humane.	
Ohio	National policy is too restrictive in providing options for pregnant teens. Promoting only chastity is not an effective way to prevent teen pregnancy.				
Oklahoma				Title IV-E is too limited in the category of children that it benefits. Ideally, it would be available to all children and adolescents needing adoption assistance.	

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State or Local Programs
Pennsylvania		Federal regulations allowing states to place high-risk postpartum women at a higher priority could result in an increase in the number of adolescents served.	Services to pregnant and parenting adolescents should not be a cash grant issue. The states should have the freedom to allow the adolescent to live in the setting which is most supportive. This setting is not always with the adolescent's nuclear family. Therefore, the rules should not force the adolescent to remain in the family home. Allowing sufficient flexibility would assist teen parents in completing their education and attaining self support.		All teenagers who need child care may apply for subsidized child care. In order to be eligible they must be working or training at least 20 hours per week and be income-eligible. The teenage parent and his/her child is the family unit and it is the teenage parent's income which is used to determine eligibility and access to services. If a teenager has no income, no fee is assessed.
Rhode Island		Current support of the program should be continued.			
South Carolina		Pregnant adolescents and their babies are in the higher priority categories and therefore would not be dropped from the program due to funding restraints.			

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State or Local Programs
South Dakota				The eligibility criteria for IV-E need to be eliminated. The children must be served by the State through the order of the courts.	
Tennessee		Strengths of WIC include: WIC certification of pregnant and parenting adolescents, in TN based on nutritional risk associated with teenage pregnancy (state policy was accepted by USDA in 1974 when program was begun). (2) Use of Administrative funds for nutrition education and for certification exams, as well as food delivery system.			In 1982, state funds were allocated for the first time specifically to provide prenatal services. Emphasis is on those at high risk, a category which includes teens.
Virginia	Parental consent requirements prevent many experienced, broad-based program providers from participating.	New Federal regulations allow pregnant teens to be given higher priority consideration for services.			
Washington	Services and support systems should be provided for those who relinquish infants	State policy should be changed to make postpartum adolescents a higher priority for	There is need to provide adequate support for basic life and safety of all children.	Adolescents who have relinquished infants for adoption should receive continuing	Federal education and job training programs need to be reviewed and modified and

State	Adolescent Family Life	WIC	AFDC	Title IV-E Adoption Assistance	Other Federal, State, or Local Programs
WA (con't)	for adoption. There is also a need to change perceptions regarding adoptions.	service, and nutrition education and outreach material to this age group.		support services, as present lack of support is a disincentive to giving up infants for adoption.	requirements should be issued for employers to provide on-site day care when possible. States should fund a minimum level of core health services. All schools should be funded to provide classes and day care services for pregnant and parenting teens. There is also need to publicly recognize and support grassroots and non-profit organizations for teen services.
West Virginia		Funding needs to be increased.	Restrictive policies have made it difficult to serve adolescent parents, (i.e., "attachment to labor force" requirement for AFDC-U is almost impossible for adolescent parents to meet).		
Wyoming		WIC is a good program in Wyoming.	State is opposed to proposed regulation that would limit AFDC to teenagers living at home and eliminate AFDC to teenagers on		More State coordination and leadership is needed on this issue.

TABLE 8: FEDERAL FUNDING FOR PREGNANT, PARENTING AND ALL ADOLESCENTS

Survey Question #10: These are examples of Federal programs with expenditures for services to adolescent parents and their children and to adolescents at risk of becoming pregnant. Please complete the chart below on the funding levels and the number of adolescents served for each of the following programs. If data exist only for programs receiving assistance from the State, please indicate.

The Federal programs listed under question #10 are as follows:

1) Title V of the Social Security Act, the Maternal and Child Health Services Block Grant

2) Title X of the Public Health Services Act, Family Planning

3) Title XIX of the Social Security Act, Medicaid

4) Title XX of the Social Security Act, Social Services Block Grant

5) Title XX of the Public Health Services Act, Adolescent Family Life Act (AFL) which, in 1981, replaced the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978

6) Education Consolidation and Improvement Act of 1981 (Chapters 1 & 2) which replaced the Elementary and Secondary Education Act in 1981

7) The Supplemental Funding Assistance Program for Women, Infants and Children (WIC)

8) Aid to Families with Dependent Children (AFDC)

9) Job Training and Partnership Act (JTPA) which replaced the Comprehensive Employment and Training Act (CETA) in 1983

10) Title IV-E of the Social Security Act, Adoption Assistance

11) Food Stamp Program

12) Low Income Public Housing

13) Leased Housing Assistance

Question #10 asked for data for the years 1978, 1980 and 1982. If States responded for other years, those years have been noted on the following chart. State funding levels were included only if amounts directed to adolescents and/or pregnant or parenting adolescents were provided. In some instances, States reported the number of adolescents, and/or the number of pregnant and parenting adolescents served, but not the amount of funding directed to this population.

FEDERAL FUNDING FOR PREGNANT, PARENTING AND ALL ADOLESCENTS

(As reported by States)

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Alabama												
APL		$276,000 100% (1981)	$298,000 100%			490						78
Title X	$1.12m 35.5%	$1.22m 33.7%	$1.34m 36.0%	19,235	21,741	26,891						
Title V					4,354	7,389					4,354	7,389
Title XX								$132,000 0.2%	$127,000 0.2%		432	461
Arizona												
Title X				24,605	26,908	24,197						
JTPA	$5.6m 43.75% (Title IIA) (1984)	$8.5m 100% (Title IIB) (1984)			4,213 (1984)	6,958 (1984)					251 (1984)	
AFDC											773 (1985)	
Arkansas												
Title X				10,233	11,292	13,425						
Title V				4,337	7,042	5,815						
California												
Title V (7 Adolescent Pregnancy Programs)			$2.4m 31.5%									

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. Of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Connecticut												
Title V (Adoles. Preg. Prevention and Serv. Program)			$166,683* (83-84)									
Delaware												
Title V				1,915	3,722	1,510						
Title X				7,070	6,390	6,377						
Title XIX		$6.80m** 15.5%	$6.83m** 11.8%	1,454	919	460						
AFDC											1,047 (1984)	
JTPA	$770,442 20.6%	$356,740 10.7%	$913,820 22.6%	2,909	1,859	1,819						
Florida												
Title X				30,336	40,118	33,304						
Title XIX	$5.7m 2.1%	$5.7m 1.4%	$8.5m 1.5%	65,068	69,458	72,182						
AFDC	$13.0m 9.4%	$18.0m 9.4%	$20.1m 9.5%	21,727	24,811 (mo. average)	24,534	$1.0m 0.7%	$1.4m 0.7%	$1.5m 0.7%	5,965	6,373	6,964
Georgia												
Title X		$439,764 11.4%	$439,764 9.4%		25,416	25,869						
Title XIX					25,416	25,869						
Title XX					25,416	25,869						

* Percentage of total funds not available.
** Federal and State funding.

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Hawaii												
AFL									$200,000 100%			
Illinois												
Title XX					1,800	2,100						
AFDC						15,064						
Title V Title XX WIC (Emergency Jobs Bill Funds)			$12.9m* (1983)									
Indiana												
Title V			$94,039 13.3%			184						
Title X and XIX		$1.12m 36.3%	$889,133 40.7%		27,740	19,308						
WIC							$180,983 7.5%	$781,567 7.4%	$1,018,872 6.9%	269	907	1,128
JTPA		40.0m 58.0% (1984)				23,500 (1984)						1,750 (1984)
AFDC												6,000
Iowa												
Title X					9,442 (1983)	8,562 (1984)						
Title V					1,303 (1983)	1,600 (1984)						

*Percentage of total funds not available.

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Kansas												
Title V (10 MIC Projects)	$335,000 12.5%	$420,000 14.2%	$530,000 18.6%	700	800	1,000	$185,000 6.9%	$268,600 9.1%	$382,000 13.4%	200	474	643
Title X	$204,000 26%	$293,695 25.9%	$334,360 26%	4,800	7,026	8,171						
WIC								$271,841 5%	$408,205 6%		860	1,150
Kentucky												
Title X	$208,000 7.7%	$421,509 14.1%		13,800	31,429	29,452						
Title V (Prenatal Care)	$54,452 2.6%	$55,000 2.2%	$70,000 2.4%	1,400	2,100	2,600	$220,100 10.7%	$218,823 8.9%	$406,088 13.7%	2,000	2,150	2,450
APL								125,000 100%				52
WIC			$3.75m 16.8%						$3.75m 16.8%			8,918
Louisiana												
APL		$80,995 100% (1982)	$286,748 100% (1984)			868			$80,995*			55
Title V (Adoles. Preg. Program in 4 Parishes)		$385,651 4%	$134,251 1.3%	446	378	219		$385,651 4%	$134,251 1.3%	446	378	219

State/Program	• Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Louisiana (con't)												
Title X	$192,410 11.7%	$110,952 6.0%	$225,000 9.0%	13,979	5,168	7,013	$100,056 6.1%	$53,257 2.9%	$112,500 4.5%	7,269	2,401	3,507
AFDC						28,921 (12/84 avg. mo.)						
Food Stamps					121,608	105,377 (avg. mo. participation)						
Maine												
Title X						4,010						
Title XIX						822						
Title XX						3,777						
AFL									$251,700 100%			2,111
Maryland												
Title X				16,661	13,117	27,864						
AFDC				37,100	36,756	34,981 32,302 (1983) 32,191 (1984)						7,000
ECIA (Chap. 1)				6,667	2,835	6,245						
Massachusetts												
AFDC												2,000 (1983)
Michigan												
AFDC (& Gen. Asst.)						15,319 (1/85)						13,219
WIC												5,259 (Year not reported)
EPSDT						24,000						

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Minnesota												
APL(family planning)			$832,213 100% (1983)									
WIC						1,200 (12/84)						
AFDC											2,420 (1984)	
Mississippi												
Title X				25,000	26,965	26,367						
Title XX			$125,000 .4%	17,364	26,465	24,511			$125,000 0.4%	101	752	154
APL			$50,000* ** (1984)									40-60
Missouri												
Title V			$169,302 2.3%			2,191						
JTPA					17,548** (**Served by balance of CETA funds)	9,824						
Montana												
Title V	$206,087*	$120,467*	$154,000*	113	180	354				94	305	244
Title X				4,912	5,620	6,364						
New Hampshire												
Title V					185 (1981)	295 (1985)						
Title X and Title XX, SS				5,126	6,626	6,924						
AFDC						932 (1985)						

* Percentage of total funds not available.
** Federal and state funding.

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
New Jersey												
Title V (Family planning)			$123,300 14.6% (1983)			1,005 (1983)						
Title X					53,300	34,100						
New Mexico												
Title V (Family Planning)						1,643						
(Adol. Preg. Serv.)												478
Title X			$34,750 3.2%			48,094						
Title XIX				12,000	13,500	13,000						
Title XX	$444,000 2.0%	$574,000 2.5%	$1.125m 5.0%									
Title IV-E					17,500	17,666						
New York												
AFDC			$25m*									
Title XX			1.7m*									
Title XIX			3.2m*									
Title V (Family Planning)			$250,000*									
(Adol. Preg. Serv.)			980,000*									
Title X			1.4m*									

*Percentage of total funds not available.

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
North Carolina												
Title V				28,604	28,660	27,654				7,427	7,508	7,420
Title X	$532,000 16.6%	$532,000 13.3%	0	35,259	42,032	43,286						
AFDC										3,203 (1980)	4,679 (1982)	4,407 (1984)
North Dakota												
Title X					2,789	2,753						
JTPA				1,801	2,500	1,893						
Title XIX	$2.04m 63.6%	$2.59m 63.7%	$4.11m 63.7%	5,813	6,027	6,241						
Title XX	$933,750 12.5%	$1.01m 12.5%	$768,413 11.2%	3,654	3,401	3,148						
AFDC	$3.26m 23.8%	$3.37m 23.8%	$3.49m 23.8%	4,952	4,850	5,161						
Oklahoma												
WIC					2,618	4,272					2,618	4,277
APL (Margaret Hudson School)		$127,526 100%	(MCHBH) $99,000 100%		3,225	6,325		$110,000 86.3%	$77,000 77.8%		225	325
AFDC				78,034	85,492	86,856						
JTPA	$13.0m 28.9%	$13.0m 28.2%	$15.74m 33.5%	13,400	13,384 (under 22)	12,490						

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Oklahoma (con't)												
Job Corps					1,010	922						
Title V	$200,000 8.3%	$180,000 7.2%	$260,000 9.9%		213	1,074					125	850
Title X	$648,500 24.7%	$599,000 24.3%	$633,200 25.5%	15,496	13,639	13,877				4406	3563	3625
Pennsylvania												
Title V (Maternity)	$853,000 41.7% (1979)	$892,000 31.7% (1981)	$855,000 28.9% (1983)	15,800 (1979)	13,730 (1981)	14,950 (1983)		$815,000 28.2% (1981)	$646,000 22.7% (1983)	2,400	2,430	2,690
(C & Y Programs)	$350,000 14.1%	$346,000 13.6%	$339,000 14.8%	3,029	2,924	2,857						
Title XX					42,807	44,610			$111,387* (child care)			
WIC									$615,000* (1985)			1,900 (mo avg)
JTPA						795 (10/83-6/84)						
AFDC										13,524 (1979)		11,092 (1983)
ECIA (Chap. 1)	$26m* (1979-80)	$24m* (80-81)	$22m* (81-82)	75,002 (1979-80)	75,342 (80-81)	68,509 (81-82)						
Rhode Island												
AFL			$100,038 100%			100						

* Percentage of total funds not available.

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
South Carolina												
APDC										680	738	441
Tennessee												
Title XIX	$31.2m 17.0%	$50.7m 19.3%	$69.7m 21.2%									
WIC												3,750
APL	$361,000 100%	$300,000 100%	$251,143 100%	7,262 1982-83	12,842 1983-84	9,402 1984-85	$161,000 44.6%	$200,000 66.7%	$171,429 66.7%	106	255	289 (6 mos.)
Texas												
Title V (Maternity)						11,400						
APDC												13,000 (1983)
Title XX (Family Planning)					63,000 (1981)							
Title XIX (Family Planning)						14,040 (1983)						
Utah												
Title X					2,789	843						
Vermont												
APDC					442 (4/84)	413 (1/85)						
APL (Addison Co. Parent/Child Center			$226,000 100% (1985)									

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Virginia												
Title X				39,000	37,000	35,000						
AFL								$0.4m 100%	$0.4m 100%		40	40
Washington												
AFL	$215,000 100% (1982)	$205,000 100% (1983)	$186,000 100% (1984)									479 (1984)
Title V			$229,817 100% (1984)			306 (1984)			$229,817* (1984)			306 (1984)
Title X				31,216 (1982)	41,692 (1983)	39,561 (1984)				5,786 (1982)	7,927 (1983)	7,945 (1984)
Title XIX									$4,082,435* (1984)			2,914 (1984)
WIC					1,353 (1983)	1,464 (1984)						
					(avg. no. caseload)							
JTPA					4,273 (10/83-6/84)							

* Percentage of total funds not available.

State/Program	Amt. & Percentage of Fed. Funding Directed to Adoles.			No. of Adoles. Served			Amt. & Percentage of Fed. Funds Directed to Pregnant and Parenting Adolescents			No. of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
West Virginia												
Title V				5,000	9,000							
Title XX	$6.06m 28.5%	$6.27m 28.7%	$6.0m 28.8%	18,934	19,384	18,671	$432,779 2.0%	$438,908 2.0%	$419,622 2.0%	484	507	491
Title X				500	10,000 1/							
Wisconsin												
Title V						32,339 (1983)						
AFL (Milwaukee Teen Preg. Service)			$257,000 100% (1984)									
AFDC						57,609						6,102 (4/84)
JTPA		$7.3m 5.7%			9,200							
ECIA (Chap. 2)			$7.76m 17.6% (1983-84)			11,329 (1983-84)					31 2/ (82-83)	31 (83-84)

1/ Court decision made contraception available to adolescents without parental consent.
2/ For one program only.

RECENT INITIATIVES IN A FEW STATES HOLD PROMISE OF MORE COMPREHENSIVE AND COORDINATED SERVICES

The ranks of States taking a leadership role on issues of adolescent pregnancy and parenthood remain small, but are growing.

Seven States, for example, reported that they have provided funds to implement comprehensive and/or coordinated statewide initiatives (California, Colorado, Illinois, Michigan, New York, Pennsylvania, Rhode Island).

These are included among the 23 States which, under the leadership of governors, State legislators and/or leaders of State agencies, have formed special task forces or study groups to help improve their current efforts, or in a few cases, have developed special initiatives to improve services.

Fifteen of the 23 States reported one of the following: (1) a special statewide initiative to provide comprehensive services; (2) statewide activities which focus on particular population subgroups or on specific kinds of interventions; or, (3) a related statewide initiative or program that includes adolescent pregnancy as a special focus (Alaska, California, Colorado, Georgia, Illinois, Maine, Michigan, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Wisconsin, and Virginia).

Fifteen States also indicated that they had or now have task forces to examine the issues (California, Colorado, Connecticut, Idaho, Illinois, Maryland, Massachusetts, Michigan, Mississippi, New York, North Carolina, North Dakota, South Carolina, Texas and West Virginia).

All the initiatives and task force efforts of the States are described on the State Fact Sheets, beginning on page 120.

IMPROVED COMPREHENSIVENESS, AS WELL AS IMPROVED HEALTH, EDUCATION AND EMPLOYMENT SERVICES ARE COMMON THEMES

Of the 23 States reporting statewide initiatives or task forces, 16 submitted reports on their activities (California, Colorado, Connecticut, Georgia, Idaho, Illinois, Maryland, Massachusetts, Michigan, New York, North Dakota, Pennsylvania, Rhode Island, South Carolina, Tennessee and Texas). They contain a fairly consistent set of strategies and programs to reduce adolescent pregnancy and the negative consequences associated with it, including recommendations covering coordination of services, health care, employment, educational services, child care, data adequacy, and public awareness and community responsiveness.

Recognizing the critical importance of providing comprehensive services, 13 of the 16 States called for, or reported already developed plans for, increased coordination among state agencies and other providers. Recommendations and actions to improve health services were raised by 12 of the 16 states, as were efforts to improve educational opportunities and interventions. Nine of the States also recommended increased vocational training and employment opportunities as part of comprehensive programs.

STATES REPORT RANGE OF LOCAL AND COMMUNITY-BASED PROGRAMS

In addition to special statewide efforts or initiatives, the survey also contained a question on model programs. (See Questions #6 and #15 on Survey in Appendix I.) All local programs which were reported in response to either of these questions are listed or referenced in the State Fact Sheets.

This section describes the kinds of programs States most often reported. Not every individual response is noted here, although these are illustrative of the range of programs which were reported.

There are, in fact, hundreds of local projects and programs which address the issue of pregnancy and parenting among adolescents, either focusing on pregnancy prevention, or targeting services to pregnant teens and teen parents. The programs tend to be located in a few areas: schools, hospitals and/or health centers, and community programs such as the Y's.

Most programs are either prevention or intervention oriented, and some combine both. Some are targeted specifically to pregnant teens, teen parents and/or infants, others to the general adolescent population.

School-Based Programs

Since most teens spend a substantial portion of their time there, schools become a likely place to provide prevention and intervention services. School location was frequently cited as a factor in achieving greater success.

Thirty-nine States reported school-based programs (Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Louisiana, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, Wisconsin and Wyoming).

These school-based programs fall into a number of different categories including: adolescent health clinics and other health-related services; adolescent pregnancy prevention programs, including family life education and health education; programs for pregnant and parenting teens which teach parenting and other skills and provide counseling and referrals; and, alternative schools, homebound programs, curricula, and child care.

Education

More than fifty percent of the States reported school-based educational programs which aim at preventing teen pregnancies, and are available to all the students (Alabama, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Virginia, Washington, Wisconsin and Wyoming).

The services offered in these prevention programs include family life education, sex education, and/or health education in at least one school. Kansas, Louisiana, Maryland and New Hampshire's Adolescent Family Life Programs are included in this group. Some States also reported special curricula to deal with this issue. New Jersey is the only State which reported a legislative mandate that family life education be taught in every public school in the State.

A total of 17 States specifically recommended increasing family life education (Connecticut, Georgia, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, North Carolina, North Dakota, South Carolina, Tennessee and Texas). Of the 23 States with statewide initiatives and task forces, seven included this emphasis. Michigan's Task Force recommended more reproductive health education, and North Dakota's Council on Problem Pregnancy argued the importance of sex education with the involvement of family members who themselves have been trained and become knowledgeable about the issues and programs.

Twenty States also reported programs which teach parenting and other skills and child development to soon-to-be, and new adolescent parents (Alabama, California, Colorado, Florida, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, North Carolina, New York, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas and Washington). These programs often provide counseling, and referrals to other needed services, and are located in regular schools.

These services are also provided at alternative schools which only enroll pregnant or parenting teenagers. Twelve States reported alternative school programs which provide prenatal and parenting education, along with an academic curriculum (Idaho, Kentucky, Maine, Massachusetts, Minnesota, New Mexico, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas and Washington). A few States mentioned homebound programs as well.

Health

Fifteen States reported programs providing school-based health services. Seven of these States have or plan to start school-based health clinic programs that offer health services to the entire student population (Connecticut, Delaware, Indiana, Michigan, Minnesota, Mississippi and New Hampshire). In addition, eight States listed programs providing health services specifically to pregnant and parenting teens (Maine, Maryland, Massachusetts, New Jersey, North Carolina, Rhode Island, South Carolina, Texas). Some programs involve a health outreach worker who, once each week, attends to the health need of the pregnant teenager. One program in North Carolina provides obstetrical and pediatric care for pregnant adolescents and the infants of students.

Four States with a special statewide initiative or task force described the need for establishing and/or expanding school-based adolescent health clinics (Connecticut, Maryland, Michigan, and South Carolina). Mississippi, which also has a task force but has not yet issued a report, noted the operation of a school-based adolescent health clinic among its model programs. Massachusetts and Texas also call for an expansion of school-based programs, with many features of adolescent health clinics.

Community-Based Programs

Many communities have recognized that adolescents have special health needs, and have responded with comprehensive programs designed specifically with them in mind. Hospitals may have a special adolescent medical section, as does one hospital in Indiana, or special clinics may be established for this age group. Some nursing associations and other health professionals have designated outreach workers to encourage pregnant and parenting teenagers to seek prenatal care, nutrition counseling, well-baby care, and general health care for themselves and their children.

Community organizations may also provide programs for this population. These programs are operated by the Y's, churches, PTA, non-profit groups, and other private organizations, among others. Examples of prevention efforts include: courses in how to resist sexual pressure, teen centers which provide social and clinical services, counseling and recreational activities, parent seminars which encourage parents to talk to their children, and teacher and community leader training.

Some community programs are also targeted toward pregnant and parenting teenagers, to help them with their new role. Job training and placement, counseling, referrals to social services, peer counseling, and support services are among the services provided by these types of programs. Several States reported maternity homes as well (Arizona, California, Delaware, Louisiana, Maryland, Massachusetts, Mississippi, Montana, North Carolina, North Dakota, Oklahoma, Tennessee, Utah, and West Virginia).

Targeting Adolescent Males and Young Fathers

With the exception of sex and health education courses in the schools, programs for at-risk, pregnant and parenting teens have traditionally focused many of their services on female adolescents, with minimal attention paid to reaching young men. While there is growing awareness and consensus in the field that young men need to be more involved in prevention and assistance efforts, few States raised male and father involvement issues in their survey responses.

Fifteen States reported on one or more issues concerning male involvement (California, Georgia, Idaho, Illinois, Maryland, Maine, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, Ohio, South Carolina, Tennessee, and Washington).

Eight of these States (California, Illinois, Maine, Missouri, New Hampshire, North Carolina, Ohio, and Tennessee) listed and/or described service programs involving adolescent males and young fathers. For example, a component of the Teenage Pregnancy and Parenting Project in San Francisco, California "ensures that young fathers receive comprehensive services." In New Hampshire, "New Directions for Young Men" specifically offers sexuality education for adolescent males. (For further description of programs, see State Fact Sheets.)

Five of the States which have special statewide initiatives or task forces included in their recommendations for improved services and programs more attention to male involvement (Georgia, Maryland, Michigan, New Hampshire, and South Carolina). South Carolina, for example, called for a greater focus on the male role in pregnancy prevention [39(e)].

Five States have proposed or already have stepped up child support collection efforts (Idaho, Illinois, Maryland, Tennessee, and Washington). Illinois reported the enactment of a child support law in 1983. Michigan's task force recommended that "service programs should actively seek to involve teen mothers, other family members and the male partner in order to meet all of the family's needs as well as to support the young women" [22(a)]. Idaho's task force report noted that "responsibility for the problems of teenage pregnancy can be returned to the responsible fathers, lessening welfare dependence for the mother" [12(a)].

Two States also encourage formal establishment of paternity (Maryland and Tennessee). Tennessee reported a new "putative father registry" (41). And, Maryland's task force recommended that "the Governor direct the Department of Human Resources to pursue vigorously establishing paternity and enforcement of child support, in cases involving teen pregnancy" [20(a)].

Public Awareness

Several of the States also called for efforts to improve public awareness and responsiveness regarding adolescent pregnancy issues. Idaho described plans for a "Community Awareness Program" to be underway in 1987, so that adolescent pregnancy problems can be better understood and addressed at the local level [12(a)]. Maryland discussed the need for local institutions to become more involved in the development and implementation of interventions and to "explore alternatives to media concentration on and exploitation of sexuality aimed at the youth market in Maryland" [20(a)].

Michigan proposed that more be done to make the adolescent population aware of the importance of prenatal care [22(a)]. And, Tennessee reported promoting "public awareness of the problems associated with teenage pregnancy with special focus on the consequences of an early pregnancy, the benefits of delaying sexual activity, and responsible behavior for those already sexually active." Tennessee also promotes greater public awareness of the choice which adoption presents to many pregnant teens [41, 41(a)].

Child Care

Eleven States reported providing school-based child care services at regular and/or alternative school sites (Connecticut, Colorado, Indiana, Massachusetts, New Jersey, New Mexico, Ohio, Tennessee, Texas, Washington, Wisconsin). Five States with special statewide initiatives or task forces raised concerns about child care and issued recommendations calling for improved child care to be included among the necessary support services for adolescent parents (Georgia, Massachusetts, Maryland, New York and Texas). Massachusetts underscored the importance of this service, referring to it as "an essential service" for the population.

STATE FACT SHEETS: A COMPILATION OF STATE RESPONSES INCLUDING DEMOGRAPHICS, HEALTH, EDUCATION AND ECONOMIC INDICATORS, ADOPTION AND FOSTER CARE, AGENCIES AND DEPARTMENTS, PROGRAMS AND RESOURCES, AND STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

States were asked to provide a wide range of information on pregnant and parenting teenagers, as well as information on how the States are responding to this problem. (See Survey, Appendix I.)

None of the States were able to provide all the information that was requested on the survey. Some States did not fill out the survey form, but submitted supplemental information such as task force reports. Oregon was the only State which did not respond to the survey at all. The fact sheets reflect the level of information provided. If a State did not answer a question, it is not included on the fact sheet.

The fact sheets are a compilation of the information provided by the States. The information is presented in eight sections:

I. DEMOGRAPHICS
II. HEALTH INDICATORS
III. EDUCATIONAL INDICATORS
IV. ECONOMIC INDICATORS
V. ADOPTION AND FOSTER CARE
VI. AGENCIES AND DEPARTMENTS
VII. PROGRAMS AND RESOURCES
VIII. STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Demographics

The Demographics section includes the number of births, abortions and miscarriages to teenagers, and the number of parenting adolescents, both married and not married.

Health

Health Indicators include the infant mortality rate, percentage of low-birthweight births, and the percentage of adolescent women receiving prenatal care in the first trimester. The infant mortality rate is reported as the number of deaths per 1000 live births, unless otherwise noted.

Education

Educational Indicators include the number of female adolescents dropping out of school, and those who cite pregnancy or child care responsibilities as reasons for leaving school. No States were able to report the number of pregnant or parenting adolescents finishing high school with their class, or within one year of their intended graduation date. In addition, none of the States reported the number of pregnant and parenting adolescents who received the G.E.D. within two years of their intended graduation date, or the number of of these students who completed vocational education programs within the same time period.

Economics

The section on Economic Indicators covers the number of pregnant and parenting adolescents receiving Aid to Families with Dependent

Children, or the State equivalent, as well as the adolescent unemployment rate. None of the States reported the number or percent of pregnant and parenting adolescents obtaining employment, or the percent of adolescent fathers paying child support.

Adoption and Foster Care

Few States provided information on adoptions or the number of infants born to teenagers who are placed in foster care.

Agencies and Departments

The survey asked States to name a department or agency with primary responsibility for programs and services for pregnant and parenting adolescents. Many States listed more than one, or none at all. The survey also asked for a list of agencies with lead responsibility for a variety of specific activities, such as family life education, child care, and maternal and infant health. If a State did not report an office or agency, that activity is omitted from the fact sheet.

Programs and Resources

The survey also asked States to list any programs or resources for pregnant or parenting adolescents, or for the prevention of teen pregnancy. It should be noted that only those programs accompanied by descriptive information were included. Therefore the list of programs and resources may be incomplete.

Initiatives and Policy Changes

Finally, the fact sheets include a narrative on major statewide initiatives concerning teen pregnancy and parenting, and recent policy changes affecting this population.

ALABAMA

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	161,719	160,211	160,358
15-19	179,303	186,614	182,477
15-17	N/A	110,102	N/A
18-19	N/A	76,512	N/A

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	406	355	275
15-19	13,409	12,693	10,987
15-17	5488	5139	4321
18-19	7515	7554	6666

Number of abortions to teenagers by age of mother

	1978	1980
10-14	260	280
15-19	5350	6000

Number of miscarriages to teenagers by age of mother

	1978	1980
10-14	110	100
15-19	3140	3150

[redacted]

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	16.7%	19.4%	13.5%	15.3%
15-17	12.0	10.7	11.5	11.1
18-19	10.1	9.3	9.6	10.0

All low-birthweight births, 1983: 7.9%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Health issues: Family Health Administration
State Department of Public Health
434 Monroe Street
Montgomery, AL 36130-1701

Contact person: Beverly W. Boyd, M.D., M.P.H,
Director
Phone number: (205) 261-5673

Education Issues: Home Economics Education
Department of Education
Room 807, State Office Building
Montgomery, AL 36130-3901
Contact person: Mrs. Sue Smith, State Specialist
Home Economics Education
Phone number: (205) 261-5184

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Adoption Services: State Department of Pensions and Security (SDP&S), Bureau of Family and Children's Services (BFCS), Division of Adoption

Child Care: SDP&S, BFCS, Division of Day Care

The Alabama Department of Public Health has primary responsibility for many of the services listed in the survey. Assorted private and public agencies are also mentioned as sharing in the responsibility for these services.

PROGRAMS AND RESOURCES

1. Parenting Education Programs and Consumer and Homemaking Education Programs. These school-based programs recieve Federal and State funds. They are implemented by Local Educuation Agencies and the State Dept. of Education.

2. Family Planning. A federally funded program that is implemented by the State Health Department and County Health Department clinics. Begun in 1973, this program is active in 67 counties.

3. Maternal and Child Health. This federally funded program is administered by the State Health Department and clinics in County Health Departments. It is active in over 50 counties with Maternal and/or Child Health programs.

4. Parent Seminars. Sponsored by the March of Dimes and the PTA, these seminars began in 1985, and are active throughout the state. There are also parent-training seminars being administered by a private group called Lighthouse, Inc.

5. Adolescent Family Life. This federally funded program began in 1983 and is active in one county.

6. Prevention programs. The Department of Pensions and Security designed five model programs to prevent teenage pregnancy. These projects were initially funded with seed money from the Federal Jobs Bill in FY 1983-84, and are administered at the local level by a local coalition, council, or task force. The projects enjoy strong community support, and utilize volunteers and the school system to reach adolescents and younger children.

Contact Persons: John Little
Charles Henderson
Child Health Center
Troy, AL 36081
Phone number: (205) 566-7600

Debra Spanos, R.N.
Jefferson County
Health Department
Box 2646
Birmingham, AL 35202
Phone: (205) 933-9110

Jane Milton
Department of
Pensions and Security
Montgomery, AL
Phone number: (205) 361-3689

7. Total Care Program, Pickens County Board of Education.

Contact person: Mrs. Laura Cummings
Charles LaDow Area Vocational Center (Pickens Co.)
Rt. 2, Box 46
Carrollton, AL 35447

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Alabama reported revising its Family Planning Protocol to include special emphasis on parental involvement in services to teenagers.

No further description was provided.

State's response to survey submitted by:

Ginger A. Roncallo
Governor's Office

ALASKA

DEMOGRAPHICS

Total female adolescent population by age

	1980
15-19	17,335

Number of births to teenagers by age of mother

	1978	1980	1981
Under 15	12	6	11
15-19	1064	1113	1180

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1978	1980	1981
Under 15	8.3%	0.0%	N/A
Under 20	N/A	N/A	6.0
15-19	7.0	6.7	N/A

All low-birthweight births, 1983: 4.7%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Division of Family and Youth Services
Pouch H-05
Juneau, AK 99811

Contact person: Betty Jo Engelman

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1985 the Alaska State Legislature appropriated $688,000 in social service spending for "pregnant women at social and economic risk," including adolescents. Eleven private agencies were awarded grants to provide the following services: foster care; residential care to pregnant women; counseling services; education and parenting skills; adoption assistance; transportation; and employment related services, including child care training and remedial education.

State's response to survey submitted by:

John R. Pugh, Commissioner
Department of Social Services

ARIZONA

DEMOGRAPHICS

Total female adolescent population by age

	1970	1980
10-14	94,980	107,990
15-19	85,501	123,734
15-17	52,483	72,191
18-19	33,018	51,543

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	108	138	123
15-19	7399	8173	7686

Number of abortions by age of mother

	1978	1980	1983
Under 20	1968	2893	3483

Number of parenting mothers by age

	1970	1980
15-19	7930	11,146
15-17	1685	3177
18-19	6245	8169

Number of married parenting mothers by age

	1970	1980
15-19	5936	7151
15-17	1270	1536
18-19	4666	5615

Number of not married parenting mothers by age

	1970	1980
15-19	1994	4195
15-17	415	1641
18-19	1579	2554

HEALTH INDICATORS

Infant mortality rate by age of mother*

	1978
Under 15	28
15-19	11

IMR for all births, 1983: 9.5
*Reported as neonatal rate

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	7.4%	14.5%	16.0%	17.1%
15-19	7.9	7.4	6.8	8.4

All low-birthweight births, 1983: 6.1%

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	April 1985
Pregnant	41
Parenting	732

Unemployment rate for 16 to 19 year olds

	1980
Total	14.3%
Teen mothers	15.6*
Teen fathers	9.8*

*Based on a 5% subsample of the 1980 Census

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

1. Office of Policy and Planning
   Arizona Department of Health Services
   1740 West Adams Street
   Phoenix, AZ 85007

   Contact person: Gloria Heller, Associate Director
   Phone number: (602) 155-1106

2. Arizona Department of Economic Security
   Division of Planning and Policy Development
   1717 West Jefferson
   Phoenix, AZ 85007

   Contact person: Sue Elliot, Assistant Director
   Phone number: (602) 255-3937

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Department of Health Services (DHS)

Preventive/Abstinence Education: Maternal and Child Health Office (MCH), DHS

Sex Education: Department of Education (DOE)

Family Life Education: DOE

Maternal Health and Medical Care: MCH

Perinatal Medical Care: MCH

Infant/Child Health and Medical Care: MCH

Educational and Vocational Assistance and/or Training: Department of Economic Security (DES), DOE

Life Skills Development Training: DES

Adoption Services: DES

Child Care: DES

New Programs and Policy Development: Office of the Governor

PROGRAMS AND RESOURCES

1. TASK (Talking About Sex with Kids). This program supports and encourages parents in talking to their children about sex. It is funded federally and by other sources. TASK makes presentions to parent gatherings at churches, YMCA's, etc. and trains people to make presentations. Begun in September 1982, TASK has made presentations to over 600 parents and trained over 100 presentors.

2. TACT (Teens and Adults Communicating Together). A program for parents of adolescents in which they discuss adolescence and skills for communicating with adolescents. With Federal and other funding, the MCH Office of the Dept. of Health Services and AZ Family Planning Council plan to finish developing the program by May 1985.

3. Via deAmisted, a program within Chicanos Por la Causa. This was funded through Project Redirection of the Manpower Demonstration Research Corporation to help young women in education, employment, counseling, and day care. It is now operating on a limited basis.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Arizona indicated recent policy changes in adoption services, adoption counseling and the involvement of fathers in adoption proceedings, but no further descriptive information was provided.

State's response to survey submitted by:

George Britton, Executive Assistant
Office of the Governor

ARKANSAS

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1980	1982
10-14	183	191	164
15-19	7201	7845	7175
15-17	2905	3064	2654
18-19	4296	4781	4521

Number of abortions to teenagers by age of mother

	1978	1980	1982
10-14	66	64	89
15-19	1823	2063	2204
15-17	817	954	931
18-19	1006	1109	1273

Number of miscarriages to teenagers by age of mother

	1978	1980	1982
10-14	11	17	21
15-19	570	522	470
15-17	258	185	188
18-19	312	337	282

ADOPTION AND FOSTER CARE

Number of adoptions of infants born to adolescents by race of mother*

	1978	1980	1982	1984
Black	36	48	57	62
White	161	170	189	154
Other	2	10	1	7

*Includes only adoptions arranged through the Department of Human Services, and not the large number of adoptions arranged privately.

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

1. Bureau of Public Health Programs
   Department of Health
   4815 West Markham Street
   Little Rock, AR 72201

   Contact person: Charles McGrow, Director of Public Health Programs
   Phone number: (501) 661-2528

2. Division of Social Services
Arkansas Department of Social Services
P.O. Box 1437
Little Rock, AR 72203

Contact person: Addie Patterson, Administrator of Family Services Section
Phone number: (501) 371-2198

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Dept. of Health (DOH)

Maternal Health and Medical Care: DOH

Infant/Child Health and Medical Care: DOH

Adoption Services: Social Services Division, Individual and Family Services, Adoption Unit

PROGRAMS AND RESOURCES

1. Teen Parenting Program. This alternative public high school is for pregnant students. Implemented by a group of public and private agencies, the program is funded by Federal, State, and private sources. It began in September 1984, and 36 adolescents have been served.

2. Unmarried Parent Program. This program is administered by the Family Services Section, Division of Social Services. It operates mainly in Little Rock.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Arkansas' Department of Health changed its parental involvement policy to require that "nurses or social workers counsel all teens, 17 years of age or younger, on the advantage of parental involvement in decision making regarding contraceptive use."

State's response to survey submitted by:

The Honorable Bill Clinton
Governor
State of Arkansas

CALIFORNIA

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1982
10-14	894,197	884,900	886,900
15-19	1,030,900	1,053,900	996,800
15-17	602,400	604,200	541,800
18-19	428,500	449,700	455,000

Number of births to teenagers by age of mother

	1978	1980	1982
Under 15	794	765	853
15-19	52,774	54,756	50,391
15-17	18,643	18,530	16,885
18-19	34,131	36,226	33,506

HEALTH INDICATORS

Infant mortality rate by age of mother

	1978	1980	1982
Under 15	22.64	20.86	28.24
15-19	16.05	14.62	12.59
18-19	N/A	N/A	12.30

IMR for all births, 1983: 9.7

Percentage of births to teenagers which are low birthweight

	1978	1980	1982
10-14	20.0%	17.7%	16.4%
15-17	N/A	N/A	8.3
18-19	N/A	N/A	7.3

All low-birthweight births, 1983: 6.0%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Pregnancy and Parenting Adolescents
Maternal and Child Health
California Department of Health Services
714 P Street, Room 300
Sacramento, CA 95814

Contact person: Peggy Russo, Health Program Specialist II
Phone number: (916) 322-9250

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Maternal and Child Health Branch, California Dept. of Health Services (MCH); Office of Family Planning (OFP), California Dept. of Health Services

Preventive/Abstinence Education: OFP, Department of Education (DOE)

Sex Education: OFP/DOE/MCH

Family Life Education: OFP/DOE/MCH

Maternal Health and Medical Care: MCH

Perinatal Medical Care: MCH

Infant/Child Health and Medical Care: MCH with Child Health and Disability Program of Calif. Dept. of Health Services

Educational and Vocational Assistance and/or Training: MCH

Adoption Services: Adoption Branch of Department of Social Services

PROGRAMS AND RESOURCES

1. Maternity Home Care Program. Mandated by the Pregnancy Freedom of Choice Act (Chapter 1190, Statutes of 1977), this State-funded program provides maternity care and related services for unwed mothers under 21 years of age. This program is under the aegis of the Adoptions Branch of the Department of Social Services and is administered under contract by seven, non-profit, licensed maternity homes.

2. Teen Pregnancy and Parenting Project (TAPP). This city-wide, inter-agency program in San Francisco provides a multi-track service system, including continuous counseling, coordination with schools, nutrition services, well-baby care, and more. 1,490 clients were served from October 1982 to September 1983.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

California's Department of Health Services has an Adolescent Pregnancy Task Force, which, in 1984, issued a position paper with recommendations on improving services. The recommendations are now part of Departmental policy on adolescent pregnancy and call for:

-- continued support of MCH-funded Adolescent Pregnancy and Parenting Programs by the Department of Health Services;
-- minimum standards for the organization and delivery of services to pregnant and parenting adolescents to be established in statute; and
-- maximum utilization of existing resources through integration and coordination among the Departments of Health Services, Education, Social Services, and Developmental Services.

In 1984, the California Office of Statewide Health Planning also developed a "Minority Health Concerns Initiative," to address a broad range of health issues for minority populations, especially pregnant and parenting black adolescents.

On October 1, 1984, California started providing State-paid, well-baby care, through the Child Health and Disability Prevention (CHDP) Program, for all infants from low-income families (up to 200% of poverty).

In July 1985, under Executive Order, California began a statewide Adolescent Family Life Program with priority for adolescents 17 years of age and under. The focus of the new effort is "through case management, to maximize use of existing resources to assure that pregnant and parenting teens receive all appropriate services in an integrated and timely manner." In addition to the service program, the initiative contains a seperate statewide evaluation component to develop a data base on the population and asses outcomes.

State's response to survey submitted by:

Kenneth W. Kizer, M.D., M.P.H., Director
Department of Health Services, State Health and Welfare agency

COLORADO

DEMOGRAPHICS

Total female adolescent population by age

	1983
10-14	112,080
15-19	126,487
15-17	73,751
18-19	52,736

Number of births to teenagers by age of mother

	1983
15-19	7000
15-17	2500
18-19	4000

Number of abortions to teenagers by age of mother

	1983
15-19	3500

Marital status of parenting adolescents

	1983
Total	15,000
Married	9000
Not married	6000

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Office of Program Development
Colorado Department of Social Services
1575 Sherman Street, Room 606
Denver, CO 80203

Contact person: Brian Golden, Director of Program Development
Phone number: (303) 866-3516

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: State Department of Health (DOH)

Preventive/Abstinence Education: DOH

Sex Education: State Department of Education

Family Life Education: Dept. of Higher Education

Maternal Health and Medical Care: DOH

Perinatal Medical Care: DOH

Infant/Child Health and Medical Care: DOH

Educational and Vocational Assistance and/or Training: Governor's Job Training Office

Life Skills Development: Dept. of Higher Ed.

Adoption Services: Dept. of Social Services (DSS)

Child Care: DSS

Evaluation: Office of State Planning and Budgeting (OSPB)

New Programs and Policy Development: OSPB

PROGRAMS AND RESOURCES

1. Work Incentive Program (WIN) Demonstration Grant. This federally funded program is implemented primarily by the Department of Social Services with the help of other service agencies. The program is aimed at moving adolescent parents who are public assistance recipients into the work force. Officially begun in February 1985, the program awaits Federal approval.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In the spring of 1984 the Task Force on Pregnant and Parenting Teens, drawn from Social Services, Health, Education, Higher Education, Labor and Employment, Job Training and Partnership Act agencies, and representatives of the Governor's office, proposed to improve services and coordination.

A "Human Service Integration" grant proposal was developed to improve coordination, as was a WIN Demonstration Grant, to improve self-sufficiency among pregnant and parenting adolescents. Although the "Human Service Integration" project failed to receive Federal funding support this year, Colorado will begin the program with State funding as soon as negotiations with localities are completed.

Colorado has compiled a State resource directory called "Teen Pregnancy/Parenting Services Guide." This lists public and private services by county, and is available through the Colorado Department of Social Services. It will be updated regularly so that available services can become better known and utilized.

State's response to survey submitted by

The Honorable Richard D. Lamm
Governor
State of Colorado

CONNECTICUT

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	130,500	125,701	114,190
15-19	142,800	142,108	133,050
15-17	N/A	86,310	N/A
18-19	N/A	55,798	N/A

Number of births to teenagers by age of mother

	1978	1980	1982	1983
10-14	80	70	74	99
15-19	4338	4334	4278	3978
15-17	1545	1502	N/A	1366
18-19	2793	2832	N/A	2612

Number of abortions to teenagers by age of mother

	1978	1980	1983
10-14	96	101	156
15-19	4066	4168	5265
15-17	1556	1537	2316
18-19	2510	2631	2949

HEALTH INDICATORS

Infant mortality rate by age of mother

	1982
Under 20	16.3

IMR for all births, 1983: 10.1

Percentage of births to teenagers which are low birthweight

	1978	1982	1983
10-14	20.0%	12.2%	13.1%
15-17	12.3	12.7	12.7
18-19	10.0	9.2	9.7

All low-birthweight births, 1983: 6.4%

AGENCIES AND DEPARTMENTS

Lead agency with responsibility for coordinating programs, policies, and projects for pregnant and parenting teenagers:

None.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1984, the General Assembly created a Task Force on Education to Prevent Adolescent Pregnancy. The Task Force report, issued in January 1985, contains the following legislative and policy recommendations:

Legislative proposals:

-- establish a Teenage Pregnancy Council, comprised of State agency heads, directors of private service agencies and legislators, to coordinate public and private resources in this area;
-- continue the Task Force as an advisory body to the interagency council;
-- institute a State Adolescent Pregnancy Prevention Grant to provide an incentive for communities to coordinate their services;
-- mandate K-12 family life education;
-- require community advisory councils for curriculum development;
-- require in-service training for all family life education teachers and establish a fund to subsidize localities for the cost;
-- create and fund a position for family life education consultant in each of the six regional educational service centers;
-- appropriate funds to fill the State Department of Education position of Health Education Consultant;
-- expand the existing school-based health clinics by providing funding to allow full-time operation;
-- provide planning and development grants to establish two new school-based health clinics, one urban and one rural;
-- adopt a limited "mature minor" statute that would allow a minor to consent to pregnancy prevention services without parental consent;
-- fund the Department of Income Maintenance's FY 1985-86 budget option to increase the Medical Assistance protected income level to 133% of the AFDC standard to ensure that families with medical expenses are better off working than on AFDC;
-- sponsor the AFDC and Wagner-Peyser model grant diversion programs for subsidized job training. This program was initially funded (but not implemented) in the FY 1984-85 Department of Income Maintenance budget;

Policy Recommendations:

-- institute training in Family Life Education issues as part of all teacher preparation programs in Connecticut colleges and universities;
-- amend the Public Health Code to change the way abortions are reported;
-- begin planning efforts toward the creation and support of programs patterned after the Boston Job Collaborative;
-- track the total annual and per-case health and support costs associated with women who become pregnant or bear a child during their teens (The Department of Income Maintenance).

The State Departments of Education, Health Services, Income Maintenance, Human Resources, Children and Youth services, and Labor administer a number of public programs related to teenage pregnancy. These are described in the Task Force Report.

State's response to survey submitted by:

Hugh M. Fritch, Analyst
Community Health Division, Department of Health Services

DELAWARE

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1980	1982
10-14	37	31	42
15-19	1439	1514	1383
15-17	583	598	512
18-19	856	916	871

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1978	1982	1984
Under 20	969	1124	918

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	1984
Under 20	1047

Unemployment rate among 16 to 19 year olds by sex

	1970	1985*
Male	2.9%	6.1%
Female	5.1	6.7

* Projected rate.

ADOPTION AND FOSTER CARE

Number and percentage of adoptions of infants born to adolescents by race of mother

	1978	1980	1982	1984
Black:				
Number	5	5	2	1
Percent	54%	45%	29%	12.5%
White:				
Number	7	6	5	7
Percent	54%	55%	71%	87.5%
Other:				
Number	1	0	0	0
Percent	8%	0%	0%	0%

Percentage of infants born to adolescents placed in foster care by race

	1978	1980	1982	1984
Black	37%	33%	40%	50%
White	63	33	40	50
Other	0	33	20	0

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Division of Public Health
Office of Adolescent Health
Department of Health and Social Services
Jesse Cooper Building
Dover, DE 19901

Contact person: Lucille Siegal, M.P.H., Director
Phone number: (302) 736-4785

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Family Planning Program, Division of Public Health (DPH)

Maternal Health and Medical Care: DPH

Perinatal Medical Care: Wilmington Medical Center

Infant/Child Health and Medical Care: DPH

Adoption Services: Children's Bureau and Catholic Social Services

PROGRAMS AND RESOURCES

1. School-Based Adolescent Health Project. This project will provide comprehensive, on-site health services, including medical, educational, and counseling services for pregnant and parenting adolescents, and services for at-risk adolescents. It is administered by the Division of Public Health, Division of Public Instruction, Wilmington Medical Center, and non-profit agencies. It is awaiting Federal funding.

2. Delaware Adolescent Program, Inc. This is a privately funded program.

Contact person: Cecily Harmon, Director
2114 Thatcher Street
Wilmington, DE 19802
Phone number: (302) 652-3445

3. Jobs Bill Demonstration Progam. A recently-completed demonstration program for low-income adolescent parents who dropped out of high school. It was administered by the Delaware Department of Health and Social Services.

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Contact person: Muriel Rusten
Director of the Division of Planning, Research, and Evaluation
Department of Health and Social Services
New Castle, DE 19720
Phone number: (302) 421-6749

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1984 the Delaware House passed a bill (H.B. 561), that would have "made eligible for Title XIX prenatal care services beginning in the fourth month of pregnancy any person who would be eligible for AFDC if they had a child."

State's response to survey submitted by:

The Honorable Michael N. Castle
Governor
State of Deleware

FLORIDA

DEMOGRAPHICS

Total female adolescent population by age

	1984 (provisional)
10-14	323,493
15-19	433,643

Number of births to teenagers by age of mother

	1978	1980	1984 (provisional)
10-14	665	646	624
15-19	22,187	23,639	22,725
15-17	8984	9005	8357
18-19	13,203	1463	14,368

Number of married parenting adolescents by age

	1978	1980	1984 (provisional)
10-14	69	57	43
15-19	10,506	10,960	9850
15-17	3160	2877	2454
18-19	7346	8083	7396

Number of not married parenting adolescents by age

	1978	1980	1984 (provisional)
10-14	581	571	592
15-19	11,414	12,396	12,769
15-17	5701	6002	5846
18-19	5713	6394	6293

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	1978	1980	1982	1984
Under 20	5965	6373	6393	6964

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting adolescents

Program, Planning and Development Office
Department of Health and Rehabilitative Services
1317 Winewood Blvd., Bldg. 1, Room 227
Tallahassee, FL 32301

Contact person: Alicia C. Smith, Assistant Secretary
Phone number: (904) 487-1111

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers

Preventive/Contraceptive Information and Services: Health and Rehabilitative Services/Health Program Office (HRS/HPO)

Preventive/Abstinence Education: HRS/HPO (Family Planning)

Family Life Education: Children, Youth and Families (CYF) Program Office; HRS

Maternal Health and Medical Care: HRS/HPO (Maternal and Child Health)

Educational and Vocational Assistance and/or Training: CYF Program Office/HRS

Adoption Services: CYF Program Office/HRS

Child Care: CYF Program Office/HRS

PROGRAMS AND RESOURCES

1. Teenage Pregnancy Program. The services of this program include prevention-related presentations in high schools and specific on-site services for pregnant teenagers. It receives State and private funds, and is administered by the non-profit Children's Home Society of Florida and the State Health and Rehabilitative Services Office (HRS). There have been presentations to 4987 students; 341 teen mothers have been served. It began in 1976.

2. The Bridge. A multi-service teen center developed and sponsored by Family Health Services (FHS), Inc. Implementation is carried out by FHS and Health and Rehabilitative Services (HRS). The Bridge provides a range of services including fertility-related health education, social services, clinic services, counseling, RAP sessions, and recreational activities. The center receives Federal and private funding. 75 teen mothers have visited the teen maternity clinic since it began in June 1983.

3. Family Involvement of Title X Adolescent Clients Education Program. These educational sessions for parents and teenagers promote family communication and the involvement of families in the sexual and parenting-related decisions teenagers make. It began in July 1984, is administered by FHS and HRS, and receives Federal Title X funding.

4. Primary Pregnancy Prevention. This program is implemented by the Broward County alumnae of Delta Sigma Theta, a public service sorority, and HRS. It receives Federal funding. Begun in 1984, they expect to renew their contract for FY 1985-86.

5. Adolescent Primary Pregnancy Prevention Learning Enrichment Project. Implemented by the Dade County Alumnae Chapter of Delta Sigma Theta, Inc. and HRS, this program receives State funding. It began in February 1985.

6. Preterm Birth Prevention Program. Aimed at reducing by half the number of low-birthweight babies in the State by 1989, the program offers patients special counseling and education on preterm labor signs and symptoms, good nutrition habits and coping with stress. Services are provided by county health units and maternal health providers under the auspices of Health and Rehabilitative Services. It began in January 1984.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Florida was one of the nine states reporting a change in parental involvement policies. The survey noted increased emphasis on parental involvement pursuant to Federal Title X requirements.

State's response to survey submitted by:

Alicia Smith, Assistant Secretary for Program Planning
Department of Health and Rehabilitative Services

GEORGIA

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	220,400	220,083	229,307
15-19	242,000	247,189	254,220

Number of births to teenagers by age of mother

	1978	1980	1981	1982	1983
10-14	613	498	432	440	446
15-19	18,002	18,475	15,927	N/A	N/A
15-17	7553	7507	N/A	N/A	6224
18-19	10,449	10,968	N/A	N/A	9703

Number of abortions by age of mother

	1978	1980	1981	1982	1983
10-14	494	388	328	373	378
15-19	8855	8516	N/A	N/A	8526
15-17	3631	3410	N/A	N/A	3606
18-19	5224	5114	N/A	N/A	4920

Number of miscarriages by age of mother

	1978	1980	1981	1982	1983
10-14	41	54	33	43	42
15-19	877	1035	N/A	N/A	1023
15-17	378	413	N/A	N/A	394
18-19	499	622	N/A	N/A	629

HEALTH INDICATORS

Infant mortality rate by age of mother*

	1982
10-14	15.9
15-17	17.8
18-19	14.7

IMR for all births, 1983: 13.4
*IMR reported as per 1000 live births

Percentage of births to teenagers which are low birthweight

	1979	1980	1982	1983
10-14	14.7%	16.5%	18.2%	14.6%
15-17	12.0	13.1	12.9	11.9
18-19	11.1	10.6	10.3	9.9

All low-birthweight births, 1983: 8.4%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1979	1980	1982	1983
Under 20	57.7%	54.8%	51.3%	53.2%

1983 rate for mothers, all ages: 75.2%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Georgia Department of Human Resources
Family Health Services
Division of Public Health
878 Peachtree Street, 2nd Floor, Room 217
Atlanta, GA 30308

Contact person: Dr. Virginia Floyd, Director
Phone number: (404) 894-6622

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Department of Human Resources, Division of Public Health (DHR/DPH)

Preventive/Abstinence Education: Grady Teen Services Program and DHR, DPH

Family Life Education: Individual local school systems

Maternal Health and Medical Care: DPH

Perinatal Medical Care: DPH

Infant/Child Health Medical Care: DPH

Educational and Vocational Assistance and/or Training: DHR - Vocational Rehabilitation

Life Skills Development Training: DHR - Mental Health

Adoption Services: Office of Children and Youth, Department of Family and Children's Services (DFACS)

Child Care: DFACS

Evaluation: DHR

New Programs and Policy Development: Office of Children and Youth-DHR

PROGRAMS AND RESOURCES

1. Maternal and Child Health (MCH) Jobs Bill Project. This project, funded by 1983 MCH Block Grant Supplemental funds, was composed of two programs; Teenage Peer Counseling, and Community Health Outreach. The combined programs were designed to address infant mortality and teenage pregnancy, and to help ease an unemployment problem within the State. The project was initiated within the Division of Public Health, and the Family Health Services Section of the Department of Human Resources in October 1983. It expired in September 1984.

2. How to Say No. Funded by Title XX, this education project for 10 to 14 year olds focuses on recognizing and resisting sexual pressure, developing communication skills, and recognizing the risk of premature sexual activity and parenting.

Contact person: Marion Howard, Ph.D.
Grady Teen Services Program
Grady Memorial Hospital
80 Butler Street, S.E.
Atlanta, GA 30303
Phone number: (404) 588-4204

3. Bridging the Gap. A series of conferences for children and parents on issues of adolescence (sexual health, drug abuse, depression), and how to communicate and prevent problems.

Contact person: Robert A. Hatcher, M.D.
Department of OB-GYN
Emory University School of Medicine
69 Butler Street, S.E.
Atlanta, GA 30335
Phone number: (404) 589-3709

4. A Healthier Generation of Georgians. (See Statewide Initiatives)

Contact Person: James G. Ledbetter, Ph.D.
Commissioner
Georgia Department of Human Resources
47 Trinity Avenue, S.W.
Atlanta, GA 30334-1202

STATEWIDE INITIAITVES AND RECENT POLICY CHANGES

The Georgia Department of Human Resources is addressing adolescent pregnancy and parenting concerns through a statewide initiative, "A Healthier Generation of Georgians." In January 1985, as part of this effort, the Department identified reduction of adolescent pregnancy as one of its major objectives. Toward that end, six strategies have been proposed:

-- heighten awareness of the consequences and the responsibilities of parenthood for both males and females, and provide family living education to children early in their lives;
-- increase the self-esteem of children and adolescents;
-- improve departmental and interdepartmental coordination of services;

-- emphasize life opportunities (making children aware of what is beyond their immediate families and/or communities);
-- increase accessible and available family planning; and
-- increase opportunities for children to remain in school.

State's response to survey submitted by:

James G. Ledbetter, Ph.D., Commissioner
Department of Human Resources

HAWAII

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1982
10-14	40,429	36,411	37,419
15-19	39,705	40,773	40,410
15-17	N/A	24,310	N/A
18-19	N/A	16,463	N/A

Number of births to teenagers by age of mother

	1978	1980	1982
10-14	20	17	22
15-19	2070	2066	2010
15-17	583	558	526
18-19	1487	1508	1484

Number of abortions by age of mother

	1978	1980	1982
10-14	32	41	38
15-19	1241	1352	1395
15-17	427	535	543
18-19	814	817	852

Number of miscarriages by age of mother

	1978	1980	1982
10-14	3	3	1
15-19	162	188	158
15-17	49	48	46
18-19	113	140	112

HEALTH INDICATORS

Infant mortality rate by age of mother

	1978	1980	1982	1983
10-14	0	58.8	0	0
15-17	15.4	14.3	11.4	14.2
18-19	11.4	9.9	13.5	12.5

IMR for all births, 1983: 9.4

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	10.0%	5.9%	9.1%	21.0%
15-17	10.1	10.9	10.3	10.6
18-19	10.0	10.3	10.6	9.2

All low-birthweight births, 1983: 7.0%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

State Department of Health
Family Health Service Division
Maternal and Child Health Branch (MCHB)
741-A Sunset Avenue
Honolulu, HI 96816

Contact person: Dr. Henry M. Ichiho, MCHB Chief
Phone number: (808) 735-3056

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents

Preventive/Contraceptive Information and Services: Department of Health - Maternal and Child Health Branch (DOH/MCHB)

Sex Education: Department of Education (DOE)

Family Life Education: DOE

Maternal Health and Medical Care: DOH/MCHB

Perinatal Medical Care: DOH/MCHB

Infant/Child Health and Medical Care: DOH/MCHB

Educational and Vocational Assistance and/or Training: DOE

Adoption Services: Department of Social Services (DSS)

Child Care: DSS

PROGRAMS AND RESOURCES

1. Hawaii Adolescent Family Life Project. This five-year demonstration project is under the aegis of the Department of Health's Maternal and Child Health Branch, and is funded through Title XX. The intent of the project is to develop, implement and evaluate case management systems for pregnant and parenting adolescents, 13 to 17 years old, in three areas in the State.

The focus of the project is on utilizing community resources through networking and coordination in a participatory process. At the end of the five-year period, it is planned that each community will assume total responsibility for the case management systems and services will continue. The project is presently in its third year.

Contact person: Amy Fekunaga Brown
Project Coordinator
741-A Sunset Avenue
Honolulu, HI 96816
Phone number: (808) 732-7332

2. Kapiolani Teen Project. This program, under the Kapiolani Women's and Children's Medical Center, evolved out of a three-year demonstration project funded under Title X. The major focus of this program is intervention and the prevention of second pregnancies among adolescents. A group of trained, teen advocates who have experienced teen pregnancy and parenthood play a major role.

Contact person: Jane Hale, Coordinator
Kapiolani Teen Project
Kapiolani Women's and
Children's Medical Center
1319 Punahou Street, Room 838
Honolulu, HI 96826
Phone number: (808) 947-8642

State's response to survey submitted by:

The Honorable George R. Ariyoshi
Governor
State of Hawaii

IDAHO

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1979	1980	1981	1982
14-17	922	874	815	736	751

Number of abortions by age of mother

	Average 1979-1981
15-17	304

Percentage of not married female adolescent parents by age

	1980
Under 20	27.5%

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	Average 1969-1982
14-17	9.0%

All low-birthweight births, 1983: 5.6%

Percentage of live births to adolescent women who recieved prenatal care in the first trimester

	Average 1968-1982
15-17	51.1%

1983 rate for mothers, all ages: 75.7%

PROGRAMS AND RESOURCES

1. Idaho Teenage Pregnancy Task Force. (See Statewide Initiatives.)

Contact Person: Dick Schultz, Director
State Health Planning and Development Agency
Department of Health and Welfare
Statehouse
Boise, ID 83720

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1984, the Idaho Department of Health and Welfare created The Idaho Teenage Pregnancy Task Force under the State Health Planning and Development Agency. The Task Force report, "Teen Pregnancy in Idaho," recommends that the State develop an information packet containing data on teenage pregnancy, an inventory of service resources, and sources of program funds available to the community for teenage pregnancy. This information will be provided to localities for use in a Community Awareness Program on teenage sexuality and pregnancy, to be estabished in each region of the State by 1987.

State's response to survey submitted by:

Dick Schultz, Director
State Health Planning and Development Agency
Department of Health and Welfare

ILLINOIS

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1982
10-14	472,935	449,963	428,700
15-19	532,817	523,270	482,500

Number of births to teenagers by age of mother

	1978	1980	1982	1983
10-14	587	609	553	516
15-19	28,047	29,174	25,013	28,832
15-17	10,919	10,721	9339	8830
18-19	17,128	18,453	15,674	15,002

Number of abortions by age of mother

	1978	1980	1982
10-14	386	307	318
15-19	14,581	13,756	12,879
15-17	5089	4879	4619
18-19	9492	8877	8260

Number of miscarriages by age of mother

	1978	1980	1982
10-14	156	159	142
15-19	7068	7210	6291
15-17	2693	2632	2330
18-19	4375	4578	3961

HEALTH INDICATORS

Infant mortality rate by age of mother

	1978	1980	1982
10-14	46.0	41.1	25.3
15-17	21.6	21.5	21.5
18-19	18.6	18.3	17.4

IMR for all births, 1983: 12.4

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	12.4%	16.6%	16.1%	15.3%
15-17	11.4	11.0	11.4	11.3
18-19	9.9	9.3	9.3	9.9

All low-birthweight births, 1983: 7.2%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	53.0%	54.8%	53.8%	53.7%

1983 rate for mothers, all ages: 77.8%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1978	1980	1982	1983
Under 20	17,969	16,078	12,048	12,202

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	1982	1983	1984
Under 20	15,064	14,957	16,755

Adolescent unemployment rate

	1978	1980	1982	1983	1984
Under 20	15.0%	19.3%	23.3%	23.5%	22.2%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Illinois Department of Public Health, Office of Health Services
Family Health Department
535 W. Jefferson Street
Springfield, IL 62761

Contact person: Ms. Linda Miller, Program Coordinator, Parents Too Soon
Phone number: (217) 782-5945

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Department of Public Health (DPH)

Preventive/Abstinence Education: DPH

Sex Education: DPH

Family Life Education: DPH

Maternal Health and Medical Care: DPH

Perinatal Medical Care: DPH

Infant/Child Health and Medical Care: DPH

Educational and Vocational Assistance and/or Training: DPH

Life Skills Development Training: DPH

Adoption Services: Department of Children and Family Services, DPH

Child Care: Department of Children and Family Services, DPH

PROGRAMS AND RESOURCES

1. Parents Too Soon. (See Statewide Initiatives)

Contact person: Linda P. Miller, Coordinator
535 West Jefferson Street
Springfield, IL 62761
Phone number: (217) 782-5945

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1983, Illinois began "Parents Too Soon" as a statewide initiative to help prevent teen pregnancy and assist pregnant and parenting adolescents. The goals are: 1) to reduce the incidence of unintended teen pregnancy; 2) to reduce the health risks associated with adolescent childbearing with an emphasis on infant mortality reduction; and 3) to assist teenagers to adapt to the responsibilities of parenthood. (See Attachment, "Parents Too Soon")

"Parents Too Soon" has coordinated and targeted a variety of services to girls and boys under age 21. These services, provided through contracts with more than 100 local agencies, include family planning, day care, vocational training, assistance in finishing high school, drug and/or alcohol counseling, home visitors, advocacy, and other support services. Since the inception of the program in 1983 the State has targeted more than $12 million of Federal support for the initiative, and in the first years of direct services more than 21,000 young people were served.

This initiative was generated by a legislatively mandated statewide task force on adolescent parent support services formed in 1980. The task force developed a comprehensive plan, including dozens of specific recommendations. In 1981, the Governor and the Department of Children and Family Services created the Ounce of Prevention Fund, to support primary prevention services to high-risk families.

"Parents Too Soon" began with funding contained in the 1983 Federal Emergency Jobs Bill. The initiative includes eleven State human services agencies and a cabinet comprised of the agencies' directors.

In addition to this major State initiative, Illinois reported two recent policy changes. In 1983, a Child Support Law was enacted, and in January 1985, the State created an adoption registry which allows adoptive and biological parents, with mutual consent, to exchange information.

State's response to survey submitted by:

Thomas B. Kirkpatrick, Jr., Director
Department of Public Health

INDIANA

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	236,800	222,501	219,100
15-19	266,200	262,939	234,900
15-17	159,800	152,979	N/A
18-19	106,400	109,960	N/A

Number of births to teenagers by age of mother

	1970	1980	1983
10-14	251	217	190
15-19	15,173	15,106	12,133
15-17	5604	5364	4204
18-19	9569	9742	7929

Number of abortions by age of mother

	1970	1980	1983
10-14	117	159	149
15-19	3903	5024	3617
15-17	N/A	N/A	1273
18-19	N/A	N/A	2344

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1980	1982	1983
10-14	11.1%	14.6%	16.9%
15-17	7.7	8.8	16.9
18-19	7.2	N/A	N/A

All low-birthweight births, 1983: 6.3%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1982	1983
Under 20	9659	9682

Number of female adolescents dropping out of school due to pregnancy or child care responsibilities

	1982	1983
Under 20	801	793

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	1985
Under 20	6000

Adolescent unemployment rate

	1978	1980	1982	1983
Under 20	17.3%	21.8%	24.8%	23.5%

OFFICES AND AGENCIES

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

None.

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive contraceptive Information and Services: Indiana Family Health Council

Sex Education: State Board of Health, Division of Health Education (SBH/DHE)

Family Life Education: SBH, DHE

Maternal and Medical Care: SBH, Division of Maternal and Child Health (DMCH)

Perinatal Medical Care: SBH, DMCH

Infant/Child Health and Medical Care: SBH, DMCH

Educational and Vocational Assistance and/or Training: Indiana Office of Occupational Development through administration of Job Training Partnership Youth Programs

PROGRAMS AND RESOURCES

1. Job Training Partnership Act Programs. Begun on November 1, 1983, these federally funded programs are implemented by the Indiana Office of Occupational Development, the Indiana Department of Employment Security, and the State Board of Vocational Education. The programs operate through schools, community organizations, and public assistance agencies.

2. Youth Forum. Begun in March 1985, this federally funded program is implemented by the Office of Occupational Development.

3. Roosevelt Adolescent Health. This program, in its fourth year of operation, is administered by the State Board of Health - MCH, and Gary Community Schools. The program is school-based, and receives Federal MCH funds.

4. Project Adolescent Health. Begun in FY84, this federally funded program is implemented by the Indiana University of Medicine, Riley Hospital for Children, and the State Board of Health.

5. Expectant Teen Outreach. Operating out of a community-based, social service agency, this program is administered by the Children's Bureau in Indianapolis, and the State Board of Health.

6. Adolescent Maternal Support. Operating out of a community mental health center, this program is implemented by the Dunn Mental Health Center and the State Board of Health.

7. School Health Outreach Project. A school-based clinic in the developmental phase that is administered by Methodist Hospital in Indianapolis, Indianapolis public schools, and the State Board of Health.

8. Helping Your Baby Grow. Implemented by United Health, this program is community based. Services offered include infant stimulation, parenting education and support services for high-risk young mothers. Begun in March 1985.

9. Adolescent Health Clinics. These clinics, in neighborhood health settings and two school settings, are implemented by the Marion County Health department and funded by the Robert Wood Johnson Foundation.

10. The Caylor-Nickel Hospital/Clinic. This is a special adolescent medical section with specific adolescent clinics.

11. The Children's Bureau of Indianapolis, Inc. proposes the establishment of a pilot program for black expectant parents, ages 12 to 18, and their families in Marion County.

Contact: Homes for Black Children
3131 East 38th Street
Indianapolis, IN

12. Youth Job Preparedness Programs, Inc. This non-profit organization is funded through the Lilly Endowment and the Presbyterian Church. It provides services to youths 14 to 16, of whom about 10 percent are pregnant or parenting. In addition to employment services, the program staff provides extensive counseling and referrals for problems associated with pregnancy.

Contact: Youth Job Preparedness Programs, Inc.
445 North State Street
Indianapolis, IN 46204
Phone number: (317) 634-1414

13. Youth Works, Inc. This non-profit group is funded through the Lilly Endowment and contributions from local businesses. It provides employment services to youths 16 to 21, of whom about 50 percent are parents.
In 1984, employment was secured for 500 youths.

Contact: Youth Works, Inc
229 North Deleware
Indianapolis, IN 46204
Phone number: (317) 923-1576

14. Indianapolis Alliance for Jobs. Through Job Training Partnership Act funds, Marion County Service Delivery Area conducted a pilot program in conjunction with the Welfare Department to provide employment and training services to welfare mothers. The program was open to youths and adults. Many of the participants were adolescent parents. Data on the program can be obtained from the Indianapolis Alliance for Jobs.

Contact: Indianapolis Alliance for Jobs
32 East Washington Street
Indianapolis, IN 46204
Phone number: (317) 639-4441

15. YWCA. Using YWCA funds, this program is designed to provide parenting skills and support to teen parents. Improving education levels, awareness of other services available, self-improvement sessions, goal setting, and employment are some of the components. The program was initiated in September 1984, and has served over 80 individuals to date.

Contact: YWCA
4460 North Guion Road
Indianapolis, IN 46204
Phone number: (317) 299-2750

16. 70,001 - Three Indiana programs. Located in three cities, these programs are supported by Federal funds and, in part, from the United Way. Specifically for youths, the Indianapolis program is currently providing pre-employment training and job placement assistance to approximately 200 youths. It is estimated that 70 to 75 percent are adolescent parents.

Contact person: Rosalie Kelly
11 South Meridian
Suite 400
Indianapolis, IN 46204
Phone number: (317) 633-7000

17. Adolescent Pregnancy Prevention Training (APPT) Project. This project will serve as a catalyst in mobilizing community support through the provision of training and technical assistance to selected community leaders. These leaders will then facilitate the development of local prevention approaches within their counties. Coordinated approaches to the prevention of adolescent pregnancy have not been established in most communities. Therefore, APPT is now in the process of contacting health, mental health, education, social work, religious and business leaders in the 20 target counties to learn more about existing services and efforts to address adolescent pregnancy prevention. APPT is funded by the Division of Maternal and Child Health, State Board of Health. Project APPT began operation in May 1984 and was funded through March 1985.

Contact persons: Theresa L. Roberts, Coordinator
Judith Kline, Consultant
Adolescent Pregnancy Prevention Training Project
Indiana Department of Education
Pupil Personnel Services
Room 229, State House
Indianapolis, IN 46204
Phone number: (317) 927-0396 or 927-0431

State's response to survey submitted by:

The Honorable Robert D. Orr
Governor
State of Indiana

IOWA

DEMOGRAPHICS

Total female adolescent population by age

	1980
10-14	112,857
15-19	137,445
15-17	78,943
18-19	58,502

Number of births to teenagers by age of mother

	1978	1980	1982
10-14	59	53	45
15-19	5860	5905	4722
15-17	1878	1756	1484
18-19	3982	4149	3338

Number of miscarriages by age of mother

	1978	1980	1982
10-14	1	1	2
15-19	64	54	42
15-17	22	20	14
18-19	44	34	28

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1978	1980	1982
10-14	16.0%	10.0%	6.7%
15-19	7.6	8.3	5.8

All low-birthweight births, 1983: 5.0%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Family/Adolescent Health
Iowa State Department of Health
Lucas State Office Building
Des Moines, IA 50319

Contact person: Carolyn S. Adams, MPA, Director
Phone number: (515) 281-3283

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: State Department of Health (SDH), Family/Adolescent Health

Sex Education: Department of Public Instruction (DPI)

Family Life Education: DPI

Maternal Health and Medical Care: SDH, Maternal Child Health (MCH)

Perinatal Medical Care: SDH, MCH

Infant/Child Health and Medical Care: SDH

Educational and Vocational Assistance and/or Training: DPI

Life Skills Development Training: DPI

Adoption Services: Department of Human Services (DHS)

Child Care: DHS

New Programs and Policy Development: SDH, Family/Adolescent Health

PROGRAMS AND RESOURCES

1. Parent Seminars. The Iowa State Department of Health contracts with the Iowa State PTA and the March of Dimes, to conduct parent seminars around the State to increase parent/child communication and thereby parental involvement. This is a federally funded project, complemented by PTA/MOD volunteers. The project began July 1, 1984.

State's response to survey submitted by:

Carolyn S. Adams, M.P.A., Director
Family/Adolescent Health Programs, Health Department

KANSAS

DEMOGRAPHICS

Total female adolescent population by age

	1980
10-14	85,693
15-19	106,237
15-17	60,606
18-19	45,631

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	72	59	49
15-19	5747	6025	4966
15-17	1943	1840	N/A
18-19	3804	4185	N/A

Estimated number of births to teenagers

	1985	1990	1995
Under 20	4750	4250	5000

Number of abortions by age of mother

	1978	1980	1983
10-14	51	61	47
15-19	2127	2485	1664
15-17	967	1038	634
18-19	1160	1447	1030

Number of not married parenting adolescents by age

	1978	1980	1983
10-14	64	55	45
15-19	1978	2234	2076

HEALTH INDICATORS

Infant mortality rate by age of mother*

	Average 1980-81-82
10-14	19.2
18-19	11.7

IMR rate for all births, 1983: 10.3
*IMR reported as per 1000 live births

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	13.9%	15.3%	11.5%	12.2%
18-19	9.0	7.7	8.3	8.3

All low-birthweight births, 1983: 6.1%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	Average 1980-81-82
Under 20	70.0%

1983 rate for mothers, all ages: 81.2%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1978	1980	1982
Under 20	3852	3063	2257

ECONOMIC INDICATORS

Adolescent unemployment rate

	1983
Under 20	10.6%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Kansas Department of Health and Environment
Division of Health
Forbes Field, Building 740
Topeka, KS 66620

Contact person: Patricia R. Schloesser, M.D., Medical Director, Maternal and Child Health Program
Phone number: (913) 862-9360

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Kansas Department of Health and Environment (KDHE)

Preventive/Abstinence Education: KDHE

Sex Education: KDHE and Department of Education (DOE)

Family Life Education: KDHE and DOE

Maternal Health and Medical Care: KDHE and Department of Social and Rehabilitation Services (SRS)

Perinatal Medical Care: KDHE and SRS

Infant/Child Health and Medical Care: KDHE and SRS

Educational and Vocational Assistance and/or Training: Department of Human Resources, SRS, and DOE

Life Skills Development Training: DOE and SRS

Adoption Services: SRS

Child Care: KDHE and SRS

Evaluation: KDHE

New Programs and Policies: KDHE

PROGRAMS AND RESOURCES

1. Maternal and Infant Care Programs. These federally and privately funded programs were initiated by the Kansas Department of Health and Environment in 1976. Projects are currently located in ten counties. The program emphasizes improving the pregnancy outcome for mother and infant, promoting efforts toward primary prevention of infant mortality, and preventing child abuse and neglect. The Maternal and Infant Care Programs provide physician and/or nursing prenatal and postpartum supervision, nutritional assessment, social-work services, parenting education and follow-up.

Contact person: Rita Kay Ryan, R.N., M.N., Ph.D.
Kansas Department of Health and Environment
Bureau of Family Health
Forbes Field
Topeka, KS 66620
Phone number: (913) 862-9360

2. Black Family Preservation Project. This federally and privately funded program is administered by the Kansas Children's Service League. The goal of this project is to help preserve and strengthen black families by decreasing the incidence of pregnancy among young, single, black women. The planning for this project began in September 1984. The first year of funding is for 1985.

Contact person: Janice Green
Black Family Preservation Project
Kansas Children's Service League
710 Minnesota Avenue
Kansas City, KS 66101
Phone number: (912) 621-2016

3. Adolescent Family Life. The Lyon County - Emporia City Health Department received Federal funding in October 1982, for an Adolescent Family Life Project containing both prevention and care components. Services include health care and education, parenting training, counseling, follow-up and support at all stages.

Contact person: Eileen Greischar, R.N.
Lyon County Health Department
802 Mechanic
Emporia, KS 66801
Phone number: (316) 342-4864

State's response to survey submitted by:

Robert C. Harder, Secretary
State Department of Social and Rehabliitation Services

KENTUCKY

DEMOGRAPHICS

Total female adolescent population by age

	1977	1979	1982
10-14	148,541	143,928	148,627
15-19	160,130	157,889	171,793
15-17	96,233	94,377	101,496
18-19	63,897	63,512	72,297

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	263	221	181
15-19	12,267	12,628	10,144
15-17	5071	4854	3725
18-19	7196	7774	6419

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	13.7%	14.5%	16.7%	13.8%
15-17	8.9	8.9	9.5	9.5
18-19	8.5	8.8	8.1	7.9

All low-birthweight births, 1983: 6.9%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	48.7%	52.2%	55.6%	55.4%

1983 rate for mothers, all ages: 75.0%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Cabinet for Human Resources
Office of the Secretary
275 East Main Street
Frankfort, KY 40621

Contact person: E. Austin, Jr., Secretary
Phone number: (502) 564-7130

Other offices and agencies with responsibility for the following activities:

Preventive/Contraceptive Information and Services: Department for Health Services (DHS)

Preventive/Abstinence Education: DHS

Sex Education: Department of Education (DOE)

Family Life Education: DOE

Maternal Health and Medical Care: DHS

Perinatal Medical Care: DHS

Infant/Child Health and Medical Care: DHS

Educational and Vocational Assistance and/or Training: DOE

Life Skills Development Training: DOE

Adoption Services: Department for Social Services (DSS)

Child Care: DSS

PROGRAMS AND RESOURCES

1. Teenage Parent Program. This program, based in the Louisville area, provides educational, counseling and health services to pregnant adolescents. The program has approximately 130 clients.

Contact person: Ms. Leslie Lawson
Louisville Area Family Planning Program
Louisville-Jefferson County Health Department
400 East Gray Street
P.O. Box 1704
Louisville, KY 40201

2. Teenage Life Choices. This program, based in the Louisville area and funded under Title X Special Project Funds, teaches decision-making skills to teenagers aged 10 to 15. The program serves approximately 50 adolescents.

Contact person: Ms. Joyce Rayzer, Director
Office of Health Affairs
City of Louisville
Public Health and Safety Cabinet
102 City Hall
Louisville, KY 40202
Phone number: (502) 587-3271

3. Young Adults Program. This program is run by the Lexington-Fayette County Health Department and serves teachers and students in seven surrounding counties as well. The program, based in the schools and in the community (churches, PTA and PTO, service clubs) teaches skills to prepare parents to provide support to their children. In FY 1984, more than 2,500 individuals participated in the program's activities.

Contact person: Ms. Donna Lemley-Jordan
Young Adults Program
Lexington-Fayette County Health Department
650 Newton Pike
Lexington, KY 40508
Phone number: (606) 252-2371

4. Adolescent Pregnancy Project. This program, funded through Title X Special Project Funds, aims to reduce infant mortality and teenage pregnancies through the development and implementation of an educational program for teachers in the Lake Cumberland District.

Contact person: Mr. Claude Tiller
Lake Cumberland District Health Department
500 Bourne Avenue
Somerset, KY 42501
Phone number: (606) 679-4417

5. Family Life Education in Southeastern Kentucky. This program of the Kentucky River District Health Department (Hazard, KY), trains teachers, and is developing a library of audio-visual resources in the area of family life education. Eleven school systems are involved in the program which is funded through a Title X Special Project Grant, and is administered in cooperation with Eastern Kentucky University in Richmond.

Contact person: Mr. Steve Henthorn
Kentucky River District Health Department
825 High Street
Hazard, KY 41701
Phone number: (606) 439-2361

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1980, the Kentucky Board of Education issued a policy concerning adolescent parenthood, stating:

> The State Board for Elementary and Secondary Education believes these young people [teenage parents] should have an opportunity to continue their education and to receive special help in meeting their family responsibilities. The Board supports a program for these young people which will encourage them to become self-supportive citizens.

The compulsory school attendance law, KRS 159.030, was amended by the 1980 General Assembly and affects married females and unmarried pregnant females under the age of 16.

State's response to survey submitted by:

C. Hernandez, M.D., M.P.H., Commissioner
Cabinet for Human Resources, Department for Health Services

LOUISIANA

DEMOGRAPHICS

Total estimated female adolescent population by age

	1978	1980	1983
10-14	187,000	182,873	176,000
15-19	214,000	212,383	200,000
15-17	125,000	124,096	117,000
18-19	89,000	88,287	83,000

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	408	365	357
15-19	15,868	16,127	14,814
15-17	6573	6150	5552
18-19	9295	9977	9262

Estimated number of births to teenagers

	1985	1990	1995
Under 20	14,368	12,835	13,642

Number of abortions by age of mother

	1978	1980	1983
10-14	165	174	202
15-19	3150	4330	4146
15-17	1206	1681	1330
18-19	1944	2649	2816

Number of miscarriages by age of mother

	1978	1980	1983
10-14	100	90	90
15-19	3490	3660	3370
15-17	1440	1400	1240
18-19	2050	2260	2130

HEALTH INDICATORS

Infant mortality rate by age of mother*

	1978	1980
10-14	41.7	24.7
15-17	25.0	18.9
18-19	19.0	15.3

IMR for all births, 1983: 13.5

*IMR reported as per 1000 live births; numerators inlude only those infant deaths which could be matched to birth certificates (85-95%).

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	16.0%	14.6%	15.8%	20.4%
15-17	11.9	12.6	11.7	12.8
18-19	10.5	10.8	10.2	10.5

All low-birthweight births, 1983: 8.6%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	50.0%	62.7%	61.2%	62.7%

1983 rate for mothers, all ages: 78.3%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1982	1983-84
Under 20	4377	5000 (approximately)

Number of female adolescents dropping out of school due to pregnancy or child care responsibilities

	1982	1983-84
Under 20	384	328

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Department of Health and Human Resources
Office of Preventive and Public Health Services
P.O. Box 60630
New Orleans, LA 70160

Contact person: Daneta Daniel Bardsley, Ed.D, Assistant Secretary
Phone number: (504) 568-5050

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Department of Health and Human Resources, Office of Preventive and Public Health Services (DHHR/OPPHS)

Preventive/Abstinence Education: Department of Education, DHHR/OPPHS - Family Planning

Sex Education: DHHR

Family Life Education: DHHR

Maternal Health and Medical Care: DHHR

Perinatal Medical Care: DHHR

Infant/Child Health and Medical Care: DHHR

Educational and Vocational Assistance and/or Training: Department of Education

Life Skills Development Training: DHHR - Division of Women

Adoption Services: DHRR - Office of Human Development

Child Care: Louisiana Association for Education of Young Children (not a public agency)

Evaluation: DHHR - Policy Planning and Evaluation

New Programs and Policy Development: DHHR - Policy Planning and Evaluation

PROGRAMS AND RESOURCES

1. Coalition for the Promotion of Healthy Families. This federally funded project, begun on December 1, 1983, is implemented primarily by the Department of Health and Human Resources (DHHR), Family Planning Program and Teen Program Services, with the help of a steering committee that includes 17 other organizations/agencies. The objectives of the first year were to develop a plan of action and identify members of the community to participate on the Board/Organizational Steering Coalition.

Contact person: Sandra L. Robinson, M.D., M.P.H.
Secretary-State Health Officer
Department of Health and Human Resources
Phone number: (504) 568-5937

2. The Ouachita Committee for the Enhancement of Family Life. This project, begun on December 12, 1982, is organized to involve the community and families of Monroe, LA. It is administered by the DHHR and the OPPHS along with eight other agencies.

3. Volunteer Program. This is a privately funded program that depends on the community for services and support. The DHHR, OPPHS - Family Planning, and Ouachita's Committee for the Enhancement of Family Life purchased evaluation materials to be used by the volunteer organization. This program began on November 1, 1983.

4. Orleans Parish School Board Adolescent Pregnancy Task Force. Funded by the Charles Stewart Mott Foundation, this project is administered by the school board, and is directed to the local public schools of the Orleans Parish. It began in September 1984.

5. Family Crisis - Personal Consequences. After administering this project in five schools in 1983, Family Services of Greater New Orleans, and Orleans Parish School System - German Protestant Orphan Asylum Foundation will repeat the project in New Orleans public schools, beginning in March 1985. The project is privately funded.

6. Northwest Louisiana Adolescent Family Life Project. This initiative networks with community organizations which promote healthy parenting skills and family involvement. Funding is provided exclusively by the DHHR and the Federal Office of Adolescent Pregnancy Programs. This project is implemented by the DHHR. It began in November 1982.

Contact person: Sandy Cahn, M.A.
1525 Fairfield, Room 569
Shreveport, LA 71130
Phone number: (318) 226-7483

7. Improved Pregnancy Outcome Project. Operating out of public hospitals and health units, this project was funded by the Federal government. The Office of Health Services and Environmental Quality, Office of Hospitals, and the Charity Hospital of New Orleans administered this project that was launched in 1977 and completed in 1984.

8. Adolescent Mothers Initiative Program. In its fifth year of operation, this program was designed to serve pregnant and parenting teens, reduce the number of repeat and unplanned pregnancies, promote self-sufficiency, and provide parenting skills and maternal and child health education. The program is administered by the National Council of Negro Women, Inc. and the National Council of Negro Women of Greater New Orleans, and receives Federal and private monies. The initiative is directed at schools, and city health clinics.

Contact person: Emma B. Bromon, Executive Director
National Council of Negro Women of Greater New Orleans
2706 South Claiborne Avenue
New Orleans, LA 70125
Phone number: (504) 897-3744

9. Reality Awareness Program for Pregnancy Prevention at the Teen Enlightenment Center. This State-funded program is in its third year of operation. Sponsored by the National Council of Negro Women of Greater New Orleans, this program is aimed at non-pregnant, in-school teenagers. It is an informational, counseling and referral program that assists parents in communicating with their teens. Its ultimate goal is to reduce the incidence of teen pregnancy and promote good health among the teen population.

10. Teen Parent Center. This newly established teen center, begun in February 1983, provides services for parents, pregnant teens and families 18 and younger. The Division of Women's Services implements this federally funded project. Services include individual and group counseling, a GED program, child care, employment training and placement, parenting workshops and life development classes. The center has served more than 450 adolescent women in two years.

11. Teen Raps. This program provides group education to teenagers who request information. Teens are able to ventilate with other teens and with a professional who has expertise in teen group dynamics, sexual decision skills and non-judgemental problem solving techniques. The rap sessions are part of the Louisiana Family Planning Program. The number of rap sessions have been significantly reduced because of earlier layoffs of public health educators.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Louisiana noted that there had been changes in four policy areas; provision of contraceptive information, sex education, maternal health and medical care. In the area of maternal health, the State noted that its Adolescent Pregnancy Project was discontinued under the MCH Block Grant. In addition, sex education policy, adopted under Louisiana's 1979 Act 480, the "Local Option for Sex Education Act" provides that,

> any public elementary school may, but is not required to, offer instruction designated as 'sex education,' provided such instruction is integrated into an existing course of study such as biology, science, physical hygiene, or physical education. Whether or not such instruction in such matter is offered and at what grade level it is to be offered shall be at the option of each public local or parish school board, provided that no such instruction shall be offered in kindergartern or in grades one through six.

In addition, the law states that proposed programs be reviewed and approved by local school boards and a parental review committee, and that programs offering sex education instruction cannot be funded with Federal funds.

State's response to survey submitted by:

The Honorable Edwin W. Edwards
Governor
State of Louisiana

MAINE

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	46,804	46,019	42,886
15-19	51,445	52,669	48,433
15-17	30,871	31,449	29,067
18-19	20,574	21,220	19,366

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	19	23	15
15-19	2579	2492	2102
15-17	788	780	633
18-19	1791	1712	1469

Number of abortions by age of mother

	1980	1983
10-14	35	26
15-19	1207	1135
15-17	N/A	468
18-19	N/A	667

Number of miscarriages by age of mother

	1980
10-14	0
15-19	95

Number of not married female adolescent parents by age

	1975	1976	1977	1978	1979	1980	1981	1982
Under 20	804	809	911	937	995	1042	1029	1046

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	5.3%	8.7%	21.4%	6.7%
15-17	8.1	7.3	7.9	9.6
18-19	6.0	6.0	7.0	7.1

All low-birthweight births, 1983: 5.6%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Division of Maternal and Child Health
Department of Human Services
Bureau of Health
Augusta, ME 04333

Contact person: Dr. John Serrage, Director, DMCH
Phone number: (207) 289-3311

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Division of Maternal and Child Health (DMCH), and Family Planning Association

Sex Education: DMCH

Family Life Education: DMCH

Maternal Health and Medical Care: DMCH

Perinatal Medical Care: DMCH

Infant/Child Health and Medical Care: DMCH

Adoption Services: Bureau of Social Services (BSS)

Child Care: BSS

PROGRAMS AND RESOURCES

1. Statewide Service Providers' Coalition on Adolescent Pregnancy. Founded in 1979, this coalition is made up of member agencies that are all service providers, and individual members. The coalition works closely with the State to review the community organizations that receive MCH Block Grant funds. The coalition also sponsors conferences.

Contact person: Patricia Anderson
Statewide Service Providers' Coalition on Adolescent Pregnancy
8 Crosby Street
Augusta, ME 04330
Phone number: (207) 622-5188

2. Family Services Program. (See Statewide Initiatives.)

Contact person: Jeannette Talbot
Research/Preventive Services Consultant
Department of Human Services
Bureau of Social Services
Augusta, ME 04333
Phone number: (207) 289-2971

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Maine began the "Family Services Program" in 1983 to assist AFDC families whose head of household is under age 20. The primary goal of the program is to "strengthen identified high risk families internally, while assisting them in accessing the services necessary to improve their lives and that of their children." The program assists participating families in education, employment and job training, maternal and infant health care, acquisition of life management skills, family counseling, and facilitation in the use of existing services.

State's response to survey submitted by:

Ellen Naor, Director
Division of Data and Research, Department of Human Services

MARYLAND

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1980	1983
Under 15	237	210	197
15-19	8520	8727	8574
15-17	3337	3209	3096
18-19	5183	5518	5478

Number of abortions by age of mother*

	1978	1980	1983
Under 15	425	401	387
15-19	8335	9063	7452
15-17	3724	4006	3095
18-19	4611	5057	4357

*By occurrence

Number of miscarriages by age of mother

	1978	1980	1982
Under 15	4	3	2
15-19	91	99	105

Number of not married female adolescent parents by age

	1978	1980	1982
Under 15	221	201	210
15-19	5154	5616	5896
15-17	2411	2455	2593
18-19	2743	3161	3303

HEALTH INDICATORS

Infant mortality rate by age of mother

	1980	1982
10-14	19.0	37.0
15-17	20.3	15.7
18-19	16.1	14.3

IMR for all births, 1983: 11.8

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	14.3%	18.1%	15.8%	15.3%
15-17	12.1	11.8	11.0	12.8
18-19	10.0	10.6	10.2	10.3

All low-birthweight births, 1983: 7.7%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1980	1982	1983
Under 20	59.5%	55.7%	55.8%

1983 rate for mothers, all ages: 78.5%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Office of the Secretary
Department of Human Resources
1100 North Eutaw Street
Baltimore, MD 21201

Contact person: Ruth Massinga, Secretary of Human Resources
Phone number: (301) 383-5528

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Department of Health and Mental Hygiene (DHMH)

Preventive/Abstinence Education: State Department of Education (SDE)

Sex Education: DHMH

Family Life Education: SDE

Maternal Health and Medical Care: DHMH

Perinatal Medical Care: DHMH

Infant/Child Health and Medical Care: DHMH

Educational and Vocational Assistance and/or Training: SDE and DHMH

Life Skills Development Training: SDE

Adoption Services: Department of Human Resources (DHR)

Child Care: DHR

PROGRAMS AND RESOURCES

1. Adolescent Pregnancy and Preventive Care Manager. Sponsored by the Department of Health and Mental Hygiene (DHMH) and local health departments, this State-funded project is directed at health departments, schools and social service departments. It began in 1982.

2. Single Parent Services Program. This State-funded program, begun in 1970, is implemented by the Department of Human Resources (DHS) and local departments of social services. It is directed at schools and communities.

3. ITV Series. The Maryland State Department of Education sponsored a 30-lesson television series for ages 14 to 21. This educational series began airing in 1980 and ended in 1981. The series provided an awareness of factors involved in becoming a parent and stressed that parenting is optional. State funds were used.

4. Single Parent Families Workshop. The Maryland State Department of Education and Maryland Department of Pupil Personnel Workers organize three 1/2 days of workshops annually. Begun in June 1977, the project is still in operation today. The workshops provide current information and ideas on working with pregnant teens and single-parent families. State funds are used.

5. State Level Interagency Initiative. Since 1984, the Maryland State Department of Education, DHR, DHMH and the Department of Employment and Training have worked cooperatively to form an interdepartmental committee on teenage pregnancy and parenting. The State supplies the funding.

6. The Baltimore City Public School System and local departments of social services have sponsored a program since 1966 in the Lawrence Paquin Jr-Sr. High School. It is a comprehensive educational program for expecting and parenting teenagers and their children. Local funding is used.

7. Adolescent Family Life Program and Service Office. This federally funded program is located at the Lawrence Paquin Jr-Sr. High School. Baltimore City Public Schools and the Maryland State Department of Education are the sponsors. The program began in July of 1983.

8. Charles County Teenage Parenting Program. This initiative is directed at schools and community health services. Since its beginning in 1976, the Charles Co. Public Schools, the Departments of Health and Social Services, Catholic Charities, Planned Parenthood and right to life church groups, have sponsored this comprehensive educational program with health and social services follow-up. The program is funded by the Local Education Agency and the Department of Health.

9. Howard County Teenage Pregnancy and Parenting Class. The Howard County Board of Education and the Departments of Health and Social Services are involved in implementing this school-based program. Classes are held one-half day per week to provide teens with parenting and social skills. This program is funded by the Local Education Agency and began in 1979.

10. Project Improve. This school and community-based program began in 1982. It is implemented by the Dorchester County Board of Education, the local health department, the Maryland State Department of Education's multi-services community-center, and local social services. Begun in 1982, the project provides interagency cooperation, parenting curriculum and a day camp for adolescent mothers. It is located in Dorchester County and funded by the Local Education Agency.

11. Roots and Wings. Initiated because of community need, this program provides comprehensive support services for teen parents such as day care, parenting training, transportation and medical resources. The emphasis is on skills training, leading to eventual employment. The project is targeted to serve 40 AFDC mothers (16 to 21 years of age). Involved with the implementation are the Department of Human

Resources/Office of Welfare Employment Policy, Dorchester County Department of Social Services, Dorchester County Board of Education, Dorchester County Health Department, Cooperative Extension Services of the University of Maryland, Dorchester County Public Library, Job Service and JTPA. It began in September 1984.

Contact person: Ms. Ardyth Coleman
Roots and Wings Program
Dorchester County Schools
Cambridge, MD 21613
Phone number: (301) 228-1093

12. I - Step in Frederick County. The aim of this initiative is to reduce welfare dependency, increase employment potential and provide extensive support services. The program is targeted to serve AFDC recipients with one child who have been on AFDC for less than 12 months, and heads of households on AFDC-UP cases. This program receives 90 percent Federal funding, and 10 percent county funding. It is administered by the Department of Human Resources/Office of Welfare Employment Policy, Frederick County Department of Social Services, Department of Employment and Training, and Job Training Agency. I - Step began in 1984 and is currently serving about 56 clients.

13. Family Support Center Programs.

Contact person: Mr. Frank Sullivan
Family Support Center Programs
Social Services Administration
300 West Preston Street
Baltimore, MD 21201
Phone number: (301) 576-5278

14. Johns Hopkins Community Adolescent Health Center.

Contact person: Ms. Rosalie Streett
Johns Hopkins Community Adolescent
Health Center
405 North Carolina Street
Baltimore, MD 21231
Phone number: (301) 955-2865

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In February 1984, the Maryland Task Force on Teen Pregnancy was appointed by the Governor and charged with "examining the issues of teen pregnancy in Maryland; exploring the current level of services offered by public and private agencies in the State; identifying gaps in coordination and delivery of services; and recommending a comprehensive approach to reduce the incidence of teen pregnancy and to help teenaged parents and their children become self-sustaining."

In September 1985, the Governor's Task Force on Teen Pregnancy issued "A Call to Action," with recommendations in seven areas:

1. Individual and family values and responsibilities

   -- support the development and implementation of character education programs;
   -- review, evaluate and update Family Life and Human Development Policy, established more than 15 years ago;
   -- provide sufficient funding for comprehensive reproductive health services including educational, medical, and counseling components which are accessible to and appropriate for teens;
   -- develop legislation that would maintain financial responsibility for the minor parent and child with his/her parents;
   -- support amendments to federal laws and/or various policies which deny independent AFDC payments to minor parents;
   -- support establishment of paternity and provision of child support in cases involving teen pregnancy;
   -- intervene, through a pilot effort providing incentives to high-risk females between the ages of 15 and 18, to prevent pregnancy;
   -- promote positive parenting and develop and implement parenting education programs for parents of all ages;

2. Community values and responsibilities

   -- work with the media, the business community, religious institutions, parent organizations, civic groups and institutions, as well as youth groups, to explore alternatives to media concentration and exploitation of sexuality aimed at the youth market in Maryland;
   -- develop community-based strategies for primary teen pregnancy prevention programs; and provide funding for a "Community Initiatives Fund" to support community-based intervention and prevention projects;

3. Educational attainment

   -- provide full equalization of State aid for public schools and assure high-risk children compensatory pre-K education, mastery of basic educational skills and effective school-to-work transitions;
   -- monitor students' attendance and performance records regularly in order to provide assistance to at-risk, pregnant and parenting teens;
   -- assist local education agencies to develop a broad spectrum of supportive services designed to assist pregnant and/or parenting teens to continue in school and complete their education;

4. Employment opportunities

   -- develop a bold, comprehensive plan of action to alleviate the chronic and worsening rate of unemployment among high-risk teens;
   -- seek increased funds and strenghten job training and employment initiatives for pregnant and parenting teens;

5. Health

-- develop a plan for a network of comprehensive school-based health care programs, with priorities to those middle and senior high schools with significant teen pregnancy problems;

6. Core services support system

-- implement Core Services Support System for at-risk, pregnant, and parenting teens which would, at minimum, include identification of the target population, an offer of services, and case management services; and

7. Statewide mobilization and coordination

-- establish a Governor's Council on Teen Pregnancy comprised of representatives of the General Assembly, public and private agencies, the general community and local governments.

Maryland's survey response also pointed out recent policy changes in the following areas: Vocational education, parental involvement, adoption services, adoption counseling, the involvement of fathers in adoption proceedings, and maternal health and medical care. The state commented that the "Carl D. Perkins Act, effective July 1985, created additional funding for vocational education for pregnant and parenting teenagers."

Additionally, in July 1984, the State's Family Planning Project policy on family involvement was approved, stating:

> The Maryland Family Planning Project strictly adheres to: (A) The Maryland Law Concerning Medical Treatment for Minors (20-102, 103 and 104 of Annotated Code of Maryland) which provides a minor age 17 or less the same capacity as an adult to consent to treatment for, or advice about, contraception other than sterilization; and (B) The Title X Program Guidelines for Project Grants for Family Planning Services which state that adolescents must be assured that the sessions are confidential and that any necessary follow-up will assure the privacy of the individual. The Maryland Family Planning Project also strongly endorses the encouragement of adolescents to communicate with parents, family members and/or other responsible adults about their decision to seek family planning services. The Maryland Family Planning Project will assist adolescent clients in communicating with parents, family members and/or other responsible adults so far as it is consistent with these clients' right to confidentiality.

With regard to adoption issues, the State made reference to a 1982 statutory revision that provides for a minor parent's consent to adoption or guardianship.

State's response to survey submitted by:

Ruth Massinga, Secretary
Department of Human Resources

MASSACHUSETTS

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1979	1980	1981	1982	1983
Under 18	2570	2550	2471	2449	2478	2345
15	N/A	N/A	N/A	N/A	N/A	341
16-17	N/A	N/A	N/A	N/A	N/A	2004
18-19	N/A	N/A	N/A	N/A	N/A	4574

Percentage of births to married teenagers by age

	1983
Under 17	20.8%
18-19	43.8

Percentage of births to unmarried teenagers by age

	1983
Under 17	79.2%
18-19	56.2

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1983
Under 16	13.2%
16-17	8.7
18-19	7.9

All low-birthweight births, 1983: 5.9%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Executive Office of Human Services
One Ashburton Place
Room 1109
Boston, MA 02108

Contact person: Mary Ann Hart, Director, Office of Health Policy

PROGRAMS AND RESOURCES

1. Coalition for Adolescent Services (Trustees of Health and Hospitals). This is an inner-city program which provides services at two neighborhood health centers and the Boston City Hospital Adolescent Center. Prenatal and pediatric care, and social services are available at all sites.

Contact person: Rosalie Williams
Trustees of Health and Hospitals
Adolescent Center, B.C.H.
5th Floor, Ambulatory Building
818 Harrison Avenue
Boston, MA 02118
Phone number: (617) 424-4086

2. Young Parent's Program. A hospital-based, teen-tot clinic with health care for mother and baby coordinated with home visiting and social services.

Contact person: Sue Perry
The Children's Hospital
Young Parent's Program
300 Longwood Avenue
Boston, MA 02115
Phone number: (617) 735-7713

3. Teen Parent Program. A tertiary level hospital-based program which includes an alternative school, a residence for pregnant women, nurse midwifery, prenatal services and a PNP teen-tot clinic. Decision-making support, mothers' groups and post-adoption support groups are offered.

Contact person: Fran Kellogg
St. Margaret's Hospital
St. Mary's Home
90 Cushing Avenue
Dorchester, MA 02125
Phone number: (617) 436-8600 X551

4. Consortium for Pregnant and Parenting Teens. A tertiary level, hospital-based program with four sites, including the hospital adolescent gynecology and prenatal clinic, two neighborhood health centers and a residence for pregnant teenagers. Alternate schooling, prenatal care, decision-making support, home visiting and follow-up services are offered.

Contact person: Candace Lowe
Brigham and Women's Hospital
Consortium for Pregnant and Parenting Teens
75 Francis Street
Boston, MA 02115
Phone number: (617) 732-4034

5. Early Childbearing Program. This program, administered by a family planning agency, uses visiting nurses and social workers to provide education and counseling to individuals and groups in the Falmouth and Taunton areas.

Contact persons: Kathleen O'Donnell
Health Care of Southeastern Massachusetts
Early Childbearing Program
19 Spring Street
Taunton, MA 02780
Phone number: (617) 822-7700

Mary Ellen Hayden
Health Care of Southeastern Massachusetts
Early Childbearing Program
VNA of Upper Cape Cod, Inc.
67 Ter Heun Drive
Falmouth, MA 02540
Phone number: (617) 584-0411

6. Healthworks. This program, administered by a family planning agency, provides educational counseling services in Haverhill in conjunction with a hospital-based prenatal clinic and a visiting nurse component.

Contact person: Jean Fox
Healthworks
Pregnant and Parenting Program
40 Buttonwoods Avenue
Haverhill, MA 01830
Phone number: (617) 374-1127

7. Services for Adolescent Family Enhancement (SAFE). The project is administered through a family planning agency for the purpose of providing coordinated case management, counseling, advocacy, follow-up and education in the Springfield area. Program staff are located in three neighborhood sites.

Contact person: Amina Ali
Family Planning Council of Western Massachusetts
Project SAFE
1618 Main Street
Springfield, MA 01103
Phone number: (413) 737-9774

8. Pregnant Adolescent Support System (PASS). The County Adolescent Network of Berkshire is a coalition of 34 agencies working together with common goals. Services are delivered in three predominantly rural county sites. Visiting nurses and social workers provide education and counseling to individuals and groups, GED preparation, an alternative school, and child development activities.

Contact person: Ann Lange
County Adolescent Network of Berkshire Co.
(CAN-BE)
PASS Project
150 North Street
Pittsfield, MA 01201
Phone number: (413) 445-4324

9. ACCESS Program.

Contact person: Fran Anthes
Family Planning Service of Central Massachusetts
ACCESS Program
71 Elm Street
Worcester, MA 01609
Phone number: (617) 756-7123

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In the spring of 1985, the Statewide Task Force on Pregnant and Parenting Youth in Massachusetts issued the report, "Uncertain Futures: Massachusetts' Teen Parents and Their Children." The Task Force was part of the Massachusetts Project to Improve Services to School-Age Parents -- a special project of the Alliance for Young Families, a non-profit youth advocacy organization. Task Force members included representatives of State-level public agencies and private foundations, providers, and technical advisors.

The report presents recommendations in several areas including:

Comprehensive and coordinated services

-- develop a State Plan as an inter-agency initiative for pregnant and parenting teens which provides education and vocational services, day care and basic services in an integrated manner;

Educational opportunities

-- legislate funding for the State's Equal Education Opportunity Act, to monitor and prevent exclusion of pregnant students from public schools and assure equal quality in alternative programs;
-- increase resources for the development of model school-based young parent programs;
-- develop and disseminate guidelines for flexible attendance and tardiness codes;
-- promulgate regulations for existing School Health Education Law;
-- develop incentives for the creation of collaborative efforts between local schools and human service agencies;
-- utilize resources for guidance services through the Federal Vocational Education Act;
-- use VEA funds to ensure elimination of sex bias in vocational education programs;
-- initiate appropriate legislative or programmatic changes to allow students to have simultaneous access to vocational and academic programs of study;
-- make basic skills remediation more available for young parents in youth employment training programs;
-- expand outreach effort through the Department of Public Welfare to inform teen parents of opportunities under the Employment and Training program;

Day care as an essential service

-- fund Department of Social Services to provide infant/toddler programs and transportation services to teen parents; consider utilizing 15% of Job Training Partnership Act (JTPA) discretionary funding for child care services;

Optimum health and welfare outcomes

-- ensure available adequate prenatal and postpartum care to all pregnant and parenting adolescents through Medicaid, private health insurance coverage and increased funding to the Department of Public Health's (DPH) Pregnant Adolescent Program;

-- establish guidelines for comprehensive and interdisciplinary health services to teen parents and disseminate them to providers throughout the State;

-- increase AFDC benefit levels to ensure a decent standard of living; and

-- support public housing policy and practice of maintaining extended family units for teen parents.

State's response to survey submitted by:

Mary Ann Hart, Director
Office of Health Policy, Executive Office of Human Services

MICHIGAN

DEMOGRAPHICS

Total estimated female adolescent population by age

	1983
10-14	352,443
15-19	437,990

Number of births to teenagers by age of mother

	1979	1980	1981	1982	1983
10-19	21,594	20,331	18,697	17,663	16,917
10-14	355	331	300	319	328
15-17	7274	6972	6342	5988	5783
18-19	13,965	13,028	12,055	11,356	10,806

Number of miscarriages by age of mother

	1983
10-19	4674
10-14	121
15-19	4553

Number of abortions by age of mother

	1983
10-19	12,356
10-14	560
15-19	11,796

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1983
Under 20	10.3%
10-14	15.5
15-19	10.2

All low-birthweight births, 1983: 7.0%

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	1985
Under 20	15,247

PROGRAMS AND RESOURCES

1. For a listing of programs available in the State under the areas of education, group homes for teens, media, peer counseling/peer education, see the Task Force report on Adolescent Pregnancy and Teen Parenting from the Michigan Department of Social Services.

Contact person: Dr. Diane C. Emling, Chairperson
Director, Office of Children and Youth Services
Michigan Department of Social Services
300 S. Capitol Avenue
Lansing, MI 48909

2. Comprehensive Community Plans. A network of contractors will plan and sponsor a diagnostic conference to identify the needs related to teen pregnancy in their perspective community, and they will develop a plan to address those needs. Local area policy-makers, practitioners, business leaders, interest groups, teens, school district personnel, and medical professionals will take part in the conference.

The model for the Comprehensive Community Plans was developed by Women and Foundations/Corporate Philanthropy through a grant from the Charles Stewart Mott Foundation. The Mott Foundation is providing the training and technical assistance for all of the contractors funded by the Department of Social Services. For a list of the participating contractors see the Task Force report on Adolescent Pregnancy and Teen Parenting.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Under the leadership of the director of the Department of Social Services, a State Task Force on Adolescent Pregnancy and Teenage Parents was created in 1984. The Task Force issued a report on its findings in October/November 1985.

Under current services, Michigan's Department of Social Services operates a statewide Teen Parenting Program. The Department was allocated $1 million in FY84 and $1.7 million in FY85 to support:

-- The development of 25 comprehensive community plans to address pregnancy prevention, prenatal health care, postnatal care for mother and infant, child abuse and neglect, high school completion or GED, and economic independence of young parents at the local level;

-- the development of 10 group homes for adolescent mothers and their infants. Each program will be designed to prepare young women to assume responsibility of family life and parenthood and prepare them for autonomous living;

-- the development of four statewide or local media campaigns to heighten awareness among male and female teens and parents of teens of the problems resulting from teen pregnancy;

-- peer counseling and peer education programs which will train teens, under the direction and supervision of adult counselors, to provide pregnancy prevention information to other teens at places where teens typically congregate; and

-- prenatal classes, parenting skills training, prevention programs, outreach programs; and a statewide conference targeted to serve teens, their families, agency personnel who provide services, and interested citizens.

The Department of Education supports regular and alternative school programs designed to support the continuation of education during and after pregnancy.

$1,210,000 was appropriated in FY 1986 to support services for approximately 4,000 school-age parents.

$910,000 for partial reimbursements of salaries of teachers providing services in 90 provider districts school-age parents programs.

$300,000 for eight comprehensive pilot programs, which provide academic, career counseling, health, nutrition, mental health, social services, transportatrion, and infant/child care services.

Furthermore, an interdepartmental effort to develop a K-8 health education curriculum has resulted in the Michigan Model for Comprehensive School Health Education. All of the health areas important to children and adolescents are presented in components or modules, including areas relating to problem solving, desicion making, prevention of sexual abuse, pregnancy, and parenting. In FY 1986, 97 schools will implement the model in 2,085 classrooms.

In addition to the Departments of Social Services and Education, the Departments of Public Health and Mental Health assist in developing and operating programs, along with a network of private agencies and foundations. Currently, no single State agency has responsibility for addressing all the issues related to teen pregnancy and parenthood, and the draft report of the statewide Task Force on Adolescent Pregnancy and Teenage Parents calls for increased coordination along with other efforts to improve services.

The Task Force Report contains more than two dozen recommendations in five areas: (1) prevention of pregnancy; (2) health services for pregnant/parenting teens; (3) education, training and support for pregnant/parenting teens; (4) economic support and residential services for pregnant/parenting teens; and (5) coordination.

State's response to survey submitted by:

Darlene Hinkle, Chief
Family Planning Program, Department of Public Health

MINNESOTA

DEMOGRAPHICS

Total female adolescent population by age

	1980	1983
10-14	162,771	153,624
15-19	197,564	171,053
15-17	114,431	N/A
18-19	83,133	N/A

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	60	45	53
15-19	6819	6988	5277
15-17	2060	1988	1521
18-19	4759	5000	3756

Number of abortions by age of mother

	1978	1980	1983
10-14	74	104	96
15-19	5166	5603	3883
15-17	2112	2223	1336
18-19	3054	3380	2547

Number of miscarriages by age of mother

	1978	1980	1983
10-14	N/A	1	2
15-19	57	51	50
15-17	N/A	13	15
18-19	N/A	38	35

Number of married parenting adolescents by age

	1978	1980	1983
10-14	N/A	3	3
15-19	3848	3634	2258
15-17	735	592	328
18-19	3113	3042	1193

Number of not married parenting adolescents by age

	1978	1980	1983
10-14	60	42	50
15-19	2971	3354	3019
15-17	1325	1396	1193
18-19	1646	1958	1826

HEALTH INDICATORS

Infant mortality rate by age of mother

	1980	1982
15-17	16.1	16.9
18-19	15.0	16.1

IMR for all births, 1983: 9.8

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	10.0%	11.1%	14.0%	9.4%
15-17	7.9	7.6	9.1	8.7
18-19	7.6	6.7	7.4	6.5

All low-birthweight births, 1983: 5.1%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	52.6%	52.8%	49.7%	49.3%

1983 rate for mothers, all ages: 79.0%

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	1984
Under 20	2420

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

None.

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Department of Health (DOH)

Preventive/Abstinence Education: Department of Education (DOE)

Sex Education: DOE

Family Life Education: DOE

Maternal and Medical Care: DOH

Perinatal Medical Care: DOH/Department of Human Services (DHS) (Medical Assistance)

Infant/Child Health and Medical Care: DOH/DHS (Medical Assistance)

Educational and Vocational Assistance and/or Training: DOE

Life Skills Development Training: DOE

Adoption Services: DHS

Child Care: DHS

PROGRAMS AND RESOURCES

1. Department of Health. The Maternal and Child Health Division provides maternal and child health technical services, including Family Planning/Reproductive Health, and WIC.

Contact person: Dr. Ronald Campbell, M.D.
Director, Maternal and Child Health
Technical Services
Minnesota Department of Health
P.O. Box 9441
717 Delaware Street, S.E.
Minneapolis, MN 55440
Phone number: (612) 623-5539

2. Department of Human Services. The Social Services Bureau offers child care, adoption and foster care, and other social services. The Income Maintenance Bureau has Medical Assistance (Medicaid), and Food Stamps.

Contact persons: Mabel Huber
Services for Unmarried Parents
Social Services Bureau
Department of Human Services
4th Floor Centennial Office Building
658 Cedar Street
St. Paul, MN 55155
Phone number: (612) 296-2279

Mary Kennedy
Health Care Programs Division
Income Maintenance Bureau
Department of Human Services
1st Floor Space Center
444 Lafayette Road
St. Paul, MN 55101
Phone number: (612) 297-3200

3. Department of Education. Sex and family life education.

Contact person: Ruth Ellen Leuhr
Department of Education
Pupil and Personnel Services
Capitol Square Building
550 Cedar Street
St. Paul, MN 55101
Phone number: (612) 296-8368

4. Minnesota Family Planning and VD Hotline. This federally funded program is implemented by the Department of Health and Family Tree, Inc. It began in 1980.

5. Minnesota submitted a list of 57 programs/services; for information contact the Departments of Health, Human Services and/or Education.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Minnesota noted policy changes regarding parental notification and abortion services. The State's "Consent of Minors for Health Services," amended in 1982, requires notification unless (1) the life of the pregnant woman is jeopardized and there is not sufficient time to provide notice; (2) the pregnant woman is a victim of abuse and there has been proper reporting of the abuse; or (3) a court intervenes and rules favorably when the pregnant woman elects not to notify.

State's response to survey submitted by:

Sister Mary Madonna Ashton, Commissioner of Health
Department of Health

MISSISSIPPI

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	389	378	333
15-19	10,590	10,693	9113
15-17	4670	4534	3750
18-19	4920	6159	5363

Number of abortions by age of mother

	1980	1983
10-14	96	112
15-19	2191	1723
15-17	903	722
18-19	1288	1001

Number of fetal deaths by age of mother

	1978	1980	1983
10-14	6	13	10
15-19	167	173	147

HEALTH INDICATORS

Infant mortality rate by age of mother

	1980	1982	1983
10-14	N/A	46.4	36.0
15-17	21.6	23.7	20.5
18-19	18.2	19.4	15.7

IMR for all births, 1983: 15.1

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	16.7%	16.1%	17.7%	16.2%
15-17	12.3	12.5	12.5	12.2
18-19	10.9	11.3	10.9	10.5

All low-birthweight births, 1983: 8.8%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	55.4%	58.4%	56.4%	57.1%

1983 rate for mothers, all ages: 74.6%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school due to pregnancy or child care responsibities

	1978	1980	1982
Under 20	748	624	521

ECONOMIC INDICATORS

Adolescent unemployment rate

	1978
Under 20	30.0%

ADOPTION AND FOSTER CARE

Number of adoptions of infants born to adolescents by race of mother

	1978	1980	1982
Total	60	43	44
Black	14	12	12
White	46	41	32

Number of infants born to adolescents placed in foster care

	1978	1980	1982
Total	0	0	0

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Governor's Commission for Children and Youth
Governor's Office of Human Development, Federal-State Programs
The Executive Building, Suite 205
802 North State Street
Jackson, MS 39201

Contact persons: Nellie Hutchinson, Director, or Linda Ross Aldy, Special Projects Officer
Phone number: (601) 354-7011

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: State Board of Health (SBH)

Preventive/Abstinence Education: SBH (as staff permits)

Sex Education: SBH

Family Life Education: SBH

Maternal Health and Medical Care: SBH

Perinatal Medical Care: SBH

Infant/Child Health and Medical Care: SBH

Life Skills Development Training: State Department of Education

Adoption Services: State Department of Public Welfare (SDPW)

Child Care: SDPW

PROGRAMS AND RESOURCES

1. Project Forward. This is a year-long pilot project, targeted at 12 to 15 year olds. Project Forward hopes to build self-esteem, promote school completion, and supplies a small allowance as incentive. The project operates out of the Department of Public Welfare, and is federally funded.

Contact person: Ms. Maurice Gregory
Region Three
515 E. Amite Street
Jackson, MS 39205
Phone number: (601) 354-0341

2. Teenage Parents and Their Babies. This program is designed to provide health education and family living information to middle through high school students in a classroom setting. The program offers individual counseling to pregnant and non-pregnant teens. The program's major focus is to prevent teen pregnancies and thereby prevent and reduce the number of at-risk babies. This program reaches approximately 3,349 students in this four-county catchment area. The program was appropriated State monies.

Contact person: Nita Thompson
Region I Mental Health Center
P.O. Box 1046
Clarksdale, MS 38614
Phone number: (601) 627-7267

3. Teenage Parents and Their Babies. This program focuses on the following three areas: parent education and counseling in child care, enriching experiences for the child, and supportive programs for parents and parents-to-be. The project has coordinated efforts with the local health department, PAL (Plan A Life) Clinic, Marshall County Health Department, and Northeast Mississippi Health Care Inc., in Byhalia, MS. The program operates in two counties.

Contact person: Mrs. Becky Meek
Region II Mental Health Center
Route 4, Box 32
Oxford, MS 38655
Phone number: (601) 234-7521

4. Teen Parent Education Program. This is a prevention program for child abuse and neglect in the high-risk teen population. Services offered to pregnant and parenting teens in the greater Jackson area are a home-based prenatal and child development educational program, volunteer parent aides, a monthly child-care newsletter, and group meetings. Over the period of one year (July 1, 1983 - June 30, 1984), 20 adolescent mothers were served. From July 1, 1984 to June 30, 1985, 40 to 60 high-risk adolescent mothers were served.

Contact person: Betty Van Gheluwe
Exchange Club Parent/Child Center
2906 N. State Street, Suite 401
Jackson, MS 39216
Phone number: (601) 366-0025

5. Adolescent Pregnancy Task Force. (See Statewide Initiatives.)

Contact persons: Ms. Nellie Hutchinson or Ms. Linda Ross-Aldy
Governor's Commission on Children and Youth
Governor's Office of Human Development
Federal-State Programs
The Executive Building, Suite 205
802 North State Street
Jackson, MS 39201
Phone number: (601) 354-7011

6. Jackson-Hinds Adolescent Pregnancy Prevention Program. This program is targeted at students in five junior high and high schools. It provides family planning services to sexually active teens and counseling for teens who are not sexually active, to encourage their postponing sexual involvement. Child care and child health services are also provided. The program operates within the school facilities and began in January 1979.

Contact person: Dr. Aaron Shirley
P.O. Box 3437
Jackson, MS 39207

7. Teen Pregnancy Reduction Project. This is an effort to reduce the incidence of teen pregnancy through the provision of case management services for sexually active teens, and to encourage the postponement of sexual involvement. The program targets teenagers in 13 primarily rural counties. Funded through Title X of the Public Health Service Act, the program began in July 1984.

Contact person: Doris Barnette
State Board of Health
P.O. Box 1700
Jackson, MS 39205
Phone number: (601) 354-6680

8. Teen Learning Center. This program encourages teenagers to stay in the educational system during and after pregnancy. In addition, health education and appropriate follow-up care are provided to improve the chances of a healthy outcome for the baby. The program operates in one county, and was launched in April of 1975.

Contact person: Dr. Margaret Morrison
P.O. Box 5465
Meridian, MS 39302
Phone number: (601) 482-3171

9. Adolescent Counseling Program. Targeted at Medicaid-eligible adolescents, 12 years of age and older, this program provides counseling services to adolescents in the area of reproductive health and contraception, sexually transmitted diseases, nutritional and dental health, and problems associated with drugs, smoking and alcohol. It was implemented in January 1985.

Contact person: Doris Barnette
State Board of Health
P.O. Box 1700
Jackson, MS 39205
Phone number: (601) 354-6680

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1985, the Governor's Office on Children and Youth established an Adolescent Pregnancy Task Force. The Task Force is conducting a survey of State and local policies and activities.

Mississippi has also changed its parental involvement, infant health and medical care, and delivery services policies. Parent involvement counseling is provided through Health Departments. Also, in 1985, Mississippi expanded Medicaid eligibility by approving legislation for the "Optional Categorically Needy."

State's response to survey submitted by:

The Honorable Bill Allain
Governor
State of Mississippi

MISSOURI

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	221	220	167
15-19	12,686	13,027	10,738
15-17	4893	4680	3715
18-19	7793	8347	7023

Estimated number of births to females

	1985	1990	1995
10-19	10,052	9893	9588

Number of abortions by age of mother

	1978	1980	1983
10-14	250	263	235
15-19	5680	6743	5660
15-17	2694	2976	2315
18-19	2986	3767	3545

HEALTH INDICATORS

Infant mortality rate by age of mother*

	1978	1980	1982	1983
10-14	31.6	45.5	27.2	47.9
15-17	22.3	16.6	19.4	19.6
18-19	22.2	17.4	12.2	13.5

IMR for all births, 1983: 10.7
*IMR reported as per 1000 live births.

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	12.2%	17.7%	15.6%	16.8%
15-17	11.2	10.5	11.1	9.9
18-19	9.9	8.6	8.3	9.1

All low-birthweight births, 1983: 6.7%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	56.5%	58.3%	56.1%	55.3%

1983 rate for mothers, all ages: 79.2%

ECONOMIC INDICATORS

Adolescent unemployment rate

	1978	1980	1982	1983
Under 20	14.9%	16.2%	21.7%	20.6%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Bureau of Family Health Care, Division of Health
Department of Social Services
1730 East Elm
Jefferson City, MO 65101

Contact person: Don Whitehead, Health Program Representative
Phone number: (314) 751-4667

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Bureau of Family Health Care, Division of Health; Family Planning Council, Inc.; Missouri Community Health Corporatiion. (BFHC/DOH/FPC, Inc/MCHC)

Preventive/Abstinence Education: Adolescent Resources Corporation (Western Missouri)

Sex Education: BFHC, DOH; FPC, Inc.; Missouri Community Action Corporation

Family Life Education: Adolescent Resources Corporation (Western Missouri)

Maternal Health and Medical Care: Public Health Prenatal Program

Perinatal Medical Care: PMR - Missouri Perinatal Association

Infant/Child Health and Medical Care: PMR - Missouri Perinatal Association

Educational and Vocational Assistance and/or Training: Department of Elementary and Secondary Education

Adoption Services: Division of Family Services, Missouri Department of Social Services (DFS/MDSS)

Child Care: DFS, MDSS

PROGRAMS AND RESOURCES

1. Adolescent Pregnancy Prevention Project. This project, funded by the MCH Block Grant, provides education, counseling, and clinical care. The Bureau of Family Health Care in the Department of Social Services, and the Adolescent Resources Corporation are involved with the implementation. Begun in 1982, this project provides over 10,000 units of service each year.

2. Project for Special Adolescent Services. This project established neighborhood teen health centers to address teen health problems. It was funded by the MCH Block Grant and was implemented by the St. Louis County Health Department and the Bureau of Family Health Care. Begun in 1984, the project terminated on January 31, 1985. There were 2,167 clinic visits in 1984.

3. Homeless Pregnant Teens Study. Sponsored by the Kansas City Mental Health Association, this 12-month study will detail the prevalence of pregnant teenagers living on the streets of Kansas City. The study team is composed of a network of Kansas City Social Service agencies.

Contact person: Harriett Lawrence
Kansas City Mental Health Association
1020 E. 63rd Street
Kansas City, MO 64110

4. MELD Young Moms. This cooperative program between the YMCA, Family and Children's Services, and the Kansas City Junior League, utilizes national MELD curricula involving an educational support-group model for teenage mothers. National data demonstrates that the project is successful in increasing the competence and confidence of young mothers.

Contacts persons: Anita Shekinah
YMCA
Phone number: (816) 842-7535

Gloria Gale
Family and Children's Services
Phone number: (816) 753-5280

Deb Weiland or Mary Kay Stranck
National MELD Office in Minneapolis
Phone number: (612) 870-4478

5. Teenage Pregnancy Prevention Project. A cooperative project between five Kansas City organizations for the purpose of providing comprehensive care to teenagers. One phase of the project is funded by the Joseph P. Kennedy Foundation and provides prenatal care and parenting education to pregnant teens. Another component of the project focuses on education and prevention by making presentations to junior and senior high school students. The project promotes the involvement of teenage fathers in the program.

Contact person: Martha Staker
St. Mary's Hospital Family Medicine Center
Phone number: (816) 756-1222

For a copy of the two year evaluation report,
Contact person: Dr. Beth Noble
Family Study Center
UMKC
School of Education
5100 Rockhill Road
Kansas City, MO 64110
Phone number: (816) 445-4545

6. Adams Center. This program provides services to pregnant teens using a foster care/adoption model.

Contact person: Susan Burden
Phone number: (816) 445-4545

State's response to survey submitted by:

Joseph J. O'Hara, Director
Department of Social Services

MONTANA

DEMOGRAPHICS

Total female adolescent population by age

	1980
10-14	30,657
15-19	36,054
15-17	21,442
18-19	14,612

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	10	14	11
15-19	1914	1742	1550
15-17	645	548	460
18-19	1269	1194	1090

Number of abortions by age of mother

	1978	1980	1983
10-14	23	22	27
15-19	1002	1066	1051
15-17	363	340	346
18-19	639	726	705

HEALTH INDICATORS

Infant mortality rate by age of mother

	1980	1982
10-14	0.0	153.8
15-17	23.7	18.3
18-19	19.3	7.0

IMR for all births, 1983: 9.0

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1984
10-14	20.0%	7.1%	0.0%	7.1%
15-17	9.0	9.7	8.5	8.7
18-19	7.7	7.1	7.0	6.9

All low-birthweight births, 1983: 5.6%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Director's Office
Department of Health and Environmental Sciences
Cogswell Building
Helena, MT 59620

Contact person: John J. Drynan, M.D., Director
Phone number: (406) 444-2544

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Department of Health and Environmental Sciences, Family Planning Program (SDHES,FPP)

Preventive/Abstinence Education: SDHES, FPP

Sex Education: SDHES, FPP, State Office of Public Instruction

Family Life Education: SDHES, Montana Perinatal Program (MPP), Healthy Mothers Healthy Babies (HMHB)

Maternal Health and Medical Care: SDHES, MPP

Perinatal Medical Care: SDHES, MPP

Infant/Child Health and Medical Care: SDHES, Clinical Services Bureau

Educational and Vocational Assistance and/or Training: Montana Department of Social and Rehabilitation Services -- Community Service Division (MDSRS - CSD)

Adoption Services: MDSRS-CSD

Child Care: MDSRS-CSD

PROGRAMS AND RESOURCES

1. Young Mothers' Program.

Contact person: Connie Fitzpatrick
Young Mothers' Program
1300 Billings
Helena, MT 59601
Phone number: (406) 442-8090

Contact: Young Mothers Program
Browning High School
Browning, MT
Phone Number: (406) 338-2715

2. Young Families Program.

Contact persons: Michelle Konzen
Young Families Program
903 N. 30th
Billings, MT 59102
Phone number: (406) 259-2007

Lois Reimers
Young Families
Sentinel High School
901 South Avenue, W.
Missoula, MT 59801
Phone number: (406) 728-2403

3. Teen Mothers.

Contact person: Jo Hatch
Teen Mothers
851 1st Avenue, S.
Great Falls, MT

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

House Joint Resolution 19, passed in 1985, requires that priority referral and placement be given to pregnant teenagers by the Department of Social and Rehabilitation Services.

Changes in child care, infant health and medical care, and maternal health and medical care policies were noted. Regarding each, "all state money has been removed from the MCH Program. Federal Block Grant funds are the only dollars available." Montana also reported that "more emphasis is placed on parental involvement," but no policy change was indicated.

State's response to survey submitted by:

Jonas H. Rosenthal
Office of the Governor

NEBRASKA

DEMOGRAPHICS

Total female adolescent population by age

	1980
10-14	59,104
15-19	72,812
15-17	41,727
18-19	31,085

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	28	32	29
15-19	3083	3280	2607
15-17	1045	1026	748
18-19	2038	2254	1859

Number of abortions to teenagers by age of mother*

	1978	1980	1983
10-14	50	49	40
15-19	1988	2060	1692
15-17	887	848	676
18-19	1101	1212	1016

*By occurrence

Number of miscarriages to teenagers by age of mother*

	1978	1980	1983
10-14	0	0	3
15-19	24	27	20

*Reported as fetal deaths at 20 or more weeks of gestation

Number of married parenting adolescents by age

	1978	1980	1983
10-14	2	1	2
15-19	1905	1867	1312
15-17	454	392	208
18-19	1451	1475	1104

Number of not married parenting adolescents by age

	1983
10-14	19
15-19	1088
15-17	445
18-19	643

HEALTH INDICATORS

Infant mortality rate by age of mother

	1978	1980	1982	1983
Under 15	71.4	0.0	30.3	0.0
15-17	23.9	13.6	21.4	18.7
18-19	15.7	14.2	13.9	13.4

IMR for all births, 1983: 9.9

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	25.0%	12.5%	3.0%	0.0%
15-17	10.4	9.7	8.6	9.9
18-19	7.4	7.5	7.2	7.5

All low-birthweight births, 1983: 5.4%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Ages 10-19	53.3%	55.9%	55.6%	54.9%

1983 rate for mothers, all ages: 80.6%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating progams, policies, and projects for pregnant and parenting teenagers

None.

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Community Health Nursing (CHN)

Preventive/Abstinence Education: CHN

Family Life Education: CHN

State's response to survey submitted by:

Gina C. Dunning, Director
Department of Social Services

NEVADA

AGENCIES AND DEPARTMENTS

Lead agency with responsibility for coordinating programs, policies, and projects for pregnant and parenting teenagers

Community Health Services
Department of Human Resources
505 East King Street, Room 600
Carson City, NV 89710

Contact person: Ann R. Malone, M.S.W., Chief, Community Health Nursing
Phone number: (702) 885-4800

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Informtion and Services: Community Health Nursing (CHN)

Preventive/Abstinence Education: CHN

Sex Education: County School Districts (CSD)

Family Life Education: CSD

Maternal Health and Medical Care: CHN; referral to local physician in county health

Perinatal Medical Care: CHN; referral to local physician in county health

Infant/Child Health and Medical Care: Community Health Nurses do well-baby exams, refer abnormalities to physicians

Educational and Vocational Assistance and/or Training: Division of Vocational Rehabilitation

Life Skills Development Training: CSD

Adoption Services: State Welfare Division

Child Care: CHN; referral to Child care centers licensed by Division of Youth Services

New Programs and Policy Development: Dept. of Human Resources

PROGRAMS AND RESOURCES

1. Family Planning Program. Begun in 1974, this federally funded initiative operates out of the Community Nursing Section of the Division of Health and Rural Community Health Nursing Offices.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Nevada noted a 1983 policy change affecting infant health and medical care: "Effective November 1, 1983, pregnant women [who are not applying for or receiving Aid to Dependent Children (ADC) for other children] may apply for and become Medicaid eligible from the date pregnancy is medically verified."

State's response to survey submitted by:

Christina Wise, Deputy Director
Department of Human Resources

NEW HAMPSHIRE

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1984 (projected)
10-14	38,760	37,079	35,923
15-19	44,600	43,559	39,996

Number of births to teenagers by age of mother

	1978	1980	1984
Under 20	1504	1467	1223

Number of married parenting adolescents by age

	1980	1984
Under 20	828	575

Number of not married parenting adolescents by age

	1980	1984
Under 20	639	648

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1982
10-14	0.7%
15-17	3.0
18-19	5.0

All low-birthweight births, 1983: 5.1%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1980
Under 20	64.0%

1983 rate for mothers, all ages: 84.8%

AGENCIES AND DEPARTMENTS

Lead agency with responsibility for coordinating programs, policies, and projects for pregnant and parenting teenagers

None.

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Bureau of Maternal and Child Health (BMCH), Family Planning.

Maternal Health and Medical Care: BMCH

Perinatal Medical Care: BMCH

Infant/Child Health and Medical Care: BMCH

Adoption Services: Division of Welfare

PROGRAMS AND RESOURCES

1. New Directions for Young Men. This federally funded project offers sexuality education for adolescent males. It is sponsored by the New Hampshire Division of Public Health Services, Bureau of Maternal and Child Health, and based at the Strafford County Prenatal and Family Planning Program in Dover, NH. It is aimed, in part, at reducing the incidence of unintended teenage pregnancy.

2. Primary Prevention in High Risk Adolescents. This proposal for a demonstration project with a school-based clinic, was modeled after the St. Paul, MN Maternal and Infant Care/Adolescent Health Services Project. This program would service junior and senior high school students in Sunapee, NH, for a demonstration period from January 1986-June 1987. It was submitted to the Federal Department of Health and Human Services, Office of Adolescent Pregnancy Programs in July 1985.

3. Teenage Pregnancy and Teenage Parent Program. Administered by the Visiting Nurse Association, Home Health Agency of Greater Manchester, this program serves pregnant and parenting teenagers and their families. Home visits, individual and/or group counseling, an eight-week prenatal education series, a support group, and a weight reduction and exercise group are the services provided. The program is funded federally and by the United Way of Greater Manchester.

Contact person: Sarah Hubbard
Executive Director
Visiting Nurse Association
Home Health Agency of Greater Manchester
194 Concord St.
Manchester, N.H. 03104
Phone number: (603) 622-3781

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Recent policy changes have been made in vocational education, standard education, parental involvement, involvement of father, child care, infant health and medical care, and maternal health and medical care. No description of these changes was provided.

State's response to survey submitted by:

Charles Albano, Bureau Chief, BMCH
Division of Public Health Services

NEW JERSEY

DEMOGRAPHICS

Total female adolescent population by age

	1978	1983
10-14	342,400	282,849
15-19	N/A	332,786

Number of births to teenagers by age of mother

	1978	1983
10-14	N/A	246
15-17	N/A	11,063
15-17	4432	4064
18-19	7408	6999

Number of abortions by age of mother

	1978	1983
10-14	198	349
15-19	N/A	7643

HEALTH INDICATORS

Infant mortality rate by age of mother

	1980	1982
10-14	17.1	24.4
15-19	18.5	18.2

IMR for all births, 1983: 11.5

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	14.0%	13.4%	13.0%	20.6%
15-19	11.7	11.5	10.9	10.9

All low-birthweight births, 1983: 7.2%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1980	1982
Under 20	50.0%	50.9%

1983 rate for mothers all ages: 80.7%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies and projects for pregnant and parenting teenagers

Five agenices are listed as having responsibility in this area.

1. Family Planning Program
   New Jersey State Department of Health
   CN 364-120 South Stockton Street
   Trenton, NJ 08625

Contact person: Dr. Alta Garfield, Co-ordinator

2. Department of Education

Contact person: Mary Guess-Flamer
Phone number: (609) 984-1971

3. Department of Human Services

Contact person: Audrey Harris
Phone number: (609) 633-6111

4. Division of Youth and Family Services

Contact person: Maria Leon
Phone number: (609) 292-0867

5. New Jersey Network on Adolescent Pregnancy

Contact persons: Estelle Robinson
Phone number: (201) 932-7798
Ann M. Wilson
Phone number: (201) 932-8636

Other offices and agencies with responsbility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Maternal and Child Health Services (MCHS)

Preventive/Abstinence Education: Family Planning Program and Family Life Education Network (FPP/FLEN)

Sex Education: FPP, FLEN, Adolescent Pregnancy Network

Maternal Health and Medical Care, Perinatal Medical Care, Infant/Child Health and Medical Care: The Maternal and Child Health Program/New Jersey State Department of Health is the lead agency to maternal, perinatal, infant and child health consultation, technical assistance and funding for the state of New Jersey. Medical Care is over-seen by the Medical Society and New Jersey Chapters of AAP and ACOG.

PROGRAMS AND RESOURCES

1. The MCH program provides prenatal, postpartum, infant and child health services to adolescents as part of its overall services. MCH Block Grant funds are used.

2. Family Life Education. (See Statewide Initiatives.)

Contact person: Cathy Waldron
NJ State Department of Education
225 West State Street
Trenton, NJ 08625

3. New Jersey Network for Family Life Education. 50 statewide private and public agencies which support family life education are involved in the implementation of this privately funded program. It is targeted at community and school groups and began in 1980.

Contact person: Roberta Knowlton
Coordinator
Rutgers University
Building 4087
Kilmer Campus
New Brunswick, NJ 08903
Phone number: (201) 932-7929

4. New Jersey Network on Adolescent Pregnancy. 200 agencies are involved with this program that provides services for pregnant teens and teen parents. Begun in 1979, it is funded by universities and private monies.

5. The Resource Book of the New Jersey Network on Adolescent Pregnancy, lists services and programs for adolescents who are pregnant, parents or at high risk. These are listed in separate books for each county. A quarterly newsletter, EXCHANGES, is put out with information for agency personnel involved in providing services to teens.

Contact persons: Ann M. Wilson
New Jersey Network on Adolescent Pregnancy
Phone number: (201) 932-8636

Estelle Robinson
Center for Community Education
Rutgers University
73 Easton Avenue
New Brunswick, NJ 08903
Phone number: (201) 932-7798

6. Hoboken Family Planning. This federally funded program tries to reach school children with information and education on family planning, as well as provide clinical services. It began in 1983.

7. Essex Planned Parenthood. This is a federally funded, school-based program which began in 1983.

8. Cumberland-Gloucestor Family Planning Program. Directed at clinics, schools and the community, this federally funded program provides health education to teenagers, and conducts outreach to find those in need. It began in 1983.

9. Mercer Planned Parenthood. A federally funded program that trained peer counselors for the community and the clinic. Begun in 1983, it was completed in 1984.

10. Atlantic City Medical Center and Family Planning Program. Directed at the community and clinic, this federally funded program provides health education and a teen clinic. It began in 1983.

11. Middlesex Adolescent Resource Services. This program is composed of a network of 30 voluntary and public agencies in one county. The network provides leadership for comprehensive approaches to needed services. It works closely with the school system.

Contact person: Karen Maxim, MARS
Rutgers CMHC
103 Bayard Street
New Brunswick, NJ 08901
Phone number: (201) 249-8500

12. Essex County Network on Adolescent Pregnancy (ECNAP). ECNAP and the March of Dimes sponser a series of workshops for pregnant and parenting teenagers. The goals of this series are to help teenagers understand their motivations, look at their futures and make viable decisions. Titles are based on popular soap operas and song titles.

Contact person: Mary-Ellen Mess
Youth Consultation Service
284 Broadway
Newark, NJ 07104
Phone number: (201) 482-8411

13. The Center for Infant Development. This infant-care center is for the children of teen parents and provides infant care and parenting training. It is administered and operated by the Elisabeth school system.

Contact person: Mary-Ellen Mess
Youth Consultation Service
284 Broadway
Newark, NJ 07104
Phone number: (201) 482-8411

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Family Life Education is required in all public schools in New Jersey as a result of NJ Public Law 6:29-7.1. It was passed in October 1983.

State's response to survey submitted by:

J. Richard Goldstein, M.D., State Commissioner of Health
Department of Health

NEW MEXICO

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1979	1980	1981	1982	1983
10-14	55	57	66	78	61	82
15-19	4535	4484	4758	4583	4741	4681
15-17	1657	1606	1718	1610	1679	1667
18-19	2878	2878	3040	2973	3062	3014

Number of abortions by age of mother

	1978	1979	1980	1981	1982	1983
10-14	33	32	35	43	38	39
15-19	1387	1362	1502	1426	1401	1273
15-17	562	588	548	571	537	471
18-19	824	774	954	855	864	802

Number of fetal deaths by age of mother

	1978	1979	1980	1981	1982	1983
10-14	0	0	0	0	1	0
15-19	40	42	28	34	38	27
15-17	11	15	10	9	17	7
18-19	29	27	18	25	20	20

Number of births to unmarried teens

	1982
Under 20	2273

HEALTH INDICATORS

Infant mortality rate by age of mother

	1978	1980	1981
10-19	13.8	11.0	N/A
10-14	N/A	N/A	12.8
15-17	N/A	N/A	14.3
18-19	N/A	N/A	13.1

IMR for all births, 1983: 10.0

Percentage of births to teenagers which are low birthweight

	1981
10-14	9.0%
15-17	9.6
18-19	9.2

All low-birthweight births, 1983: 7.6%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1981	1983
Under 20	22.3%	26.0%

1983 rate for mothers, all ages: 61.5%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1978	1982
Under 20	2582	3103

Number of female adolescents dropping out of school due to pregnancy or child care responsibilities

	1982
Under 20	484

ECONOMIC INDICATORS

Adolescent unemployment rate

	1980
16-19	22.4%

AGENCIES AND DEPARTMENTS

Lead agency responsibile for coordinating programs, policies, and projects for pregnant and parenting teenagers

Maternal and Child Health Bureau
Health and Environment Department
Education Outreach, family planning, prenatal clinics
725 St. Michael's Drive
Santa Fe, NM 87501

Contact person: Jeffery M. Davis, M.D., Bureau Chief
Phone number: (505) 984-0020

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Maternal and Child Health Bureau (MCHB)

Sex Education: MCHB

Maternal Health: Health and Environment Department

Medical Care: HSD

Infant/Child Health and Medical Care: MCHB, HSD-EDSET

Educational and Vocational Assistance and/or Training: Department of Education (DOE)

Life Skills Development Training: DOE

Adoption Services: Human Services Department (HSD)

Child Care: HSD

PROGRAMS AND RESOURCES

1. Family Planning Program. The Health and Environment Department implements this federally and State-funded program. It is directed at clinics through public health and contracting agencies.

2. New Mexico Organization on Adolescent Pregnancy. Begun in 1980, this privately funded program aims at community education and coordination, and is administered by private and governmental agencies and individual citizens.

3. New Futures School. This comprehensive program for pregnant and parenting teenagers provides educational services, counseling and social services, health services and day care facilities. Since opening in January 1970, the Perinatal Program has served approximately 3,150 clients. The Young Parent's Center has served about 577 clients since it opened in November 1979.

Contact person: Caroline Gaston
Project Coordinator
New Futures School
2120 Louisiana , N.E.
Albuquerque, NM 87110
Phone number: (502) 883-5680

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

New Mexico reported a change in parental involvement policy, but no description of the change was provided.

State's response to survey submitted by:

Diana Pacheco, Administrative Assistant
Governor's Office of Children and Youth

NEW YORK

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	714,528	689,056	615,257
15-19	795,563	794,932	735,653
15-17	474,741	472,900	430,795
18-19	320,822	322,032	304,858

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	523	511	506
15-19	28,397	27,699	26,791
15-17	10244	9968	9477
18-19	18,153	17,731	17,314

Number of abortions to teenagers by age of mothers

	1978	1980	1983
10-14	1064	1201	1277
15-19	31,972	32,936	33,291
15-17	12,126	13,026	13,099
18-19	19,846	19,910	20,192

Number of miscarriages to teenagers by age of mothers

	1978	1980	1983
10-14	38	44	33
15-19	1307	1445	1292
15-17	472	510	485
18-19	835	935	807

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Council on Children and Families
Mayor Erastus Corning 2nd Tower, 28th Floor
Empire State Plaza
Albany, NY 12223

Contact person: Dr. Joseph J. Cocozza, Executive Director
Phone number: (518) 474-8038

Additional contact: Suzanne Sennett, Coordinator of the Governor's Task Force on Adolescent Pregnancy

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Department of Health, Bureau of Reproductive Health (BRH)

Family Life Education: State Education Department

Maternal Health and Medical Care: BRH

Perinatal Medical Care: BRH

Infant/Child Health and Medical Care: Department of Health, Bureau of Child Health

Educational and Vocational Assistance and/or Training: Department of Labor and State Education Department

Life Skills Development Training: Department of Social Services (DSS)

Adoption Services: DSS

Child Care: DSS

Evaluation: Council on Children and Families and each dept. as appropriate

New Programs and Policy Development: Council on Children and Families and each dept. as appropriate

PROGRAMS AND RESOURCES

1. Case Management Service Program. Developed in response to the Teenage Services Act of 1984, this program is State-funded and administered by the Division of Family and Children's Services, Department of Social Services. An advisory board has been established. It is developing guidelines for submission of proposals.

2. Teenage Pregnancy Program. The Department of Social Services awards State funds to public and private agencies in communities with the greatest pregnancy problems. Included are a wide range of services, with 50 percent of the funds going to prevention programs and 50 percent to supportive services (e.g. counseling, health care, and help finding employment).

3. Family Planning, local assistance. This is a State and locally funded program that provides family planning services for low-income clients at no cost.

4. Supportive Services. The Division of Families and Youth provides a range of counseling and educational services to at-risk youths, pregnant adolescents and teen parents, in such areas as health, education, and employment.

5. Family Life Program. This program was designed to provide regional coordination and limited financial support to participating school districts, to help plan and develop family life curricula focusing on human sexuality and parenting. It is administered by the State Education Department, through local school districts.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1984, under the direction of the Governor, New York began a major statewide initiative designed to address the problems of adolescent pregnancy. It contains two major components: The Governor's Task [illegible]rce on Adolescent Pregnancy, and a funding program, the Adolescent Pr[illegible]ncy Prevention and Services Program.

The Task Force report, issued in February 1985, underscores the historically piecemeal and uncoordinated approaches, and the failure to focus adequately on preventive strategies. It proposed instead, "a prevention strategy which takes a more fundamental approach to addressing the causes of adolescent pregnancy .... Central to the framework developed by the Task Force is an increased emphasis on and refocusing of prevention efforts. Past attempts to prevent adolescent pregnancy have centered on youth already in crisis."

The following recommendations are highlighted in the Task Force report:

- -- review current policies and practices which have an impact on adolescent pregnancy;
- -- further explain the concept of youth and family development and propose an appropriate balance with services for pregnant and parenting adolescents;
- -- develop strategy for implementing the comprehensive state policy;
- -- involve a broad spectrum of individuals and groups;
- -- identify existing programs and approaches which promote youth and family development;
- -- strenghten the ability of major institutions and community organizations to promote youth and family development;
- -- identify effective models for the delivery of coordinated, comprehensive services for serving pregnant, parenting and at-risk adolescents;
- -- develop recommendations to ensure cost-effective funding of services for pregnant, parenting and at-risk teens;
- -- help to promote the quality and on-going effectiveness of services;
- -- promote the broader involvement of the community, including the media, in primary prevention strategies and activities;
- -- increase the knowledge and sensitivity of policymakers, administrators, and the service providers to the needs of youth; and
- -- encourage a broader application of youth and family development strategies across youth issues and concerns.

The funding program, the Adolescent Pregnancy Prevention and Services Program, (Chapter 974, NYS Laws, 1984) has four principal components: prevention; greater opportunities for self-sufficiency; improved coordination; and broader community involvement. It has received a $5 million appropriation.

State's response to survey submitted by:

Joseph J. Cocozza, Executive Director
Council on Children and Families

NORTH CAROLINA

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	239,548	235,785	229,013
15-19	271,041	273,807	252,761

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	374	466	390
15-19	16,961	24,545	21,866
15-17	6700	9094	7546
18-19	10,261	15,451	14,302

Number of abortions to teenagers by age of mother

	1978	1980	1983
10-14	422	430	384
15-19	8352	9630	8921

HEALTH INDICATORS

Infant mortality rate by age of mother

	1978	1980	1982	1983
Under 15	32.1	32.5	24.7	25.7
15-17	25.8	19.7	19.2	21.2
18-19	22.4	16.8	16.2	17.7

IMR for all births, 1983: 13.2

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	15.5%	12.7%	17.0%	17.0%
15-17	11.7	12.3	12.1	12.1
18-19	10.6	9.8	9.8	9.6

All low-birthweight births, 1983: 7.8%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	53.9%	55.5%	56.7%	57.1%

1983 rate for mothers, all ages: 77.8%

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	1980	1982	1984
Under 20	3203	4679	4407

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting adolescents

Maternal and Child Care Section
Division of Health Services, Dept. of Human Resources
P.O. Box 2091
Raleigh, NC 27602

Contact person: Dr. Verna Y. Barefoot, Section Chief
Phone number: (919) 733-3816

(North Carolina reports that no agency has lead responsibility for these activities, but gives the Maternal and Child Care Section as a contact and information source.)

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Family Planning Branch, Maternal and Child Care Section, Division of Health Services (FPB/MCCS/DHS/)

Preventive/Abstinence Education: FPB

Sex Education: FPB

Family Life Education: FPB

Maternal Health and Medical Care: Maternal and Child Health Branch (MCHB), MCCS, DHS

Perinatal Medical Care: MCHB

Education and Vocational Assistance and/or Training: Dept. of Public Instruction (DPI)

Life Skills Development Training: DPI

Adoption Services: Dept. of Social Services (DSS)

Child Care: DSS

PROGRAMS AND RESOURCES

1. The Adolescent Parenting Program. This program includes a range of individual and group services aimed at prevention. The intensive family-centered services promote family stability and solve problems which may lead to abuse, neglect, or delinquency of children. The

program focuses on first-time parents, 16 years of age and younger, supporting their continued schooling, utilization of social and health care services, development of parenting and life skills, and eventual self-sufficiency. The program is funded by Federal, State, and local sources. It is administered by the State Division of Social Services and County Departments of Social Services. It is in the implementation stage in eight counties.
(Note: The Program is a modified version of Project Redirection, tested by the Manpower Demonstration Research Corporation.)

2. Postponing Sexual Involvement. (See Statewide Initiatives.)

Contact person: Vicki Gerig
Family Planning Branch
P.O. Box 2091
Raleigh, N.C. 27602
Phone number: (919) 733-4871

3. Statewide Coalition on Early Adolescent Pregnancy. This coalition involves approximately 50 public and private, youth-serving and policy-making agencies and groups, at the State and local level. It receives private funding and began in November 1979.

4. Interagency Agreement to Reduce Infant Deaths and Improve Infant Health. Local public schools, health departments, and social services agencies, under the aegis of the Department of Human Resources and the Department of Public Instruction, have a formal agreement to work toward improved infant health. It began in July 1980.

5. Technical Assistance to Local Coalitions. An effort by community organizations that is directed by the Governor's Advocacy Council on Children and Youth. Begun in 1981, over 30 coalitions assisted this privately funded project.

6. Single Parent Source Book. This resource index for single parents, many of whom are adolescents, was published and distributed in 1980 by the Center for Urban Affairs and Community Services. It was funded by Federal Title I, Higher Education money.

7. Spranz Grant. This grant, to fund four local projects of an innovative nature to reduce adolescent pregnancy, is to be administered by county health departments, schools, and local youth-serving agencies, under the Division of Health Services and the Department of Public Instruction. It is to be funded with Federal MCH Block Grant money. It was proposed in August 1985.

8. Adolescent Risk Reduction Funds. These funds, supplied by the Division of Health Services and county and State agencies, are to be implemented by county and State agencies, under the State Division of Health Services. It was proposed in June of 1985.

9. Child Health Counseling Program. This program offers one-to-one counseling and support for teenage mothers. The range of services are aimed at enhancing the parenting abilities of young mothers, preventing them from dropping out of school, preventing subsequent, unwanted pregnancies, and maximizing the mothers' long-term employment opportunities. It is an ongoing program of the Durham County Health Department, and is funded with county and State money. 704 mothers have been served since 1977.

Contact person: John Fletcher, M.D.
Durham County Health Department
414 E. Main Street
Durham, NC 27701
Phone number: (919) 688-9375

10. Community Teen Outreach Program of the Vance County Health Department. This program aims to increase awareness of teen pregnancy and parenting issues on the part of parents, teenagers, and community members, and to have parents lead discussion groups with teenagers about sexuality. Begun in 1983, and funded by Title X monies, the program is administered by the NC Family Planning Program.

Contact person: Dennis Retzlaff, Program Consultant
NC Family Planning Program
Phone number: (919) 247-1092

11. Teenage Pregnanacy Coalitions. These are citizen coalitions in 34 counties, trying to raise awareness and educate local communities about teenage pregnancy, to reduce the incidence of teen pregnancy, and to establish programs to support teenage parents. It is supported by the Governor's Advocacy Council on Children and Youth and the Mary Reynolds Babcock Foundation, with leadership from local health departments and family planning advisory boards. Over 800 local citizens serve on these coalitions.

Contact person: Ms. Helen Hill
Green County Health Care
Box 657
Snow Hill, NC
Phone number: (919) 747-2921

12. Teens and Tots Clinic. A hospital-based clinic which provides multi-service health care to teenage mothers and their babies at one site. Health education, contraceptive services, gynecological exams, WIC, and other social services are also provided. Fathers are encouraged and included in the program. Costs are absorbed by Medicaid, patient fees, and the hospital operating budget. 150 families have been served.

Contact person: Suzanne White, M.D.
Wake Medical Center
Raleigh, NC
Phone number: (919) 755-8000

13. Wake Teen Medical Services. This program in Raleigh, which provides medical, contraceptive, and counseling services to teenagers who are sexually active, aims to provide these services in a way that is appropriate for adolescents. It is funded with private grants and patient fees. 300 teens and their families have participated.

Contact person: Michael F. Durfree, M.D.
619 Oberlin Road
Raleigh, NC
Phone number: (919) 828-0035

14. Let's Talk Campaign. This campaign is designed to increase awareness and sensitize communities to the issues surrounding teenage pregnancy. Included are a media campaign, telephone surveys, community forums, and the establishment of coalitions. The campaign is active in three counties, and is supported by the Babcock Foundation and local health departments. It was developed by Emory University, and is now in the follow-up stage.

Contact person: Josie Hookway
Pitt County Health Department
1825 W. 6th Street
Greenville, NC
Phone number: (919) 752-4141

15. Adolescent Parent Prevention Program. This is a school-based program in Greene County, for adolescent parents. Services provided include obstetrical and pediatric care for mothers and their babies, counseling, referrals to community resources, nutritional services, and health services for the general school population. It is funded by a three-year grant from the Office of Adolescent Pregnancy, with a possible two-year extension.

Contact person: Helen Hill
Greene County Health Care
Box 657
Snow Hill, NC
Phone number: (919) 747-2291

16. Pre-adolescent Gynecological Clinic. This clinic, located at the local health department in Pitt County, operates one day a week for adolescents under 15 years of age. It receives ongoing county and private grant money. 150 adolescents and their parents have been served.

Contact person: Josie Hookway
Pitt County Health Department
1825 W. 6th Street
Greenville, NC
Phone number: (919) 752-4141

17. How To Say No Campaign. This ongoing, long-term campaign, is channeled through health fair exhibits, forums, workshops, brochures, interagency linkages, etc. It promotes community awareness and local efforts regarding adolescent pregnancy, and encourages teenagers to resist pressures regarding sexual activities. It is active in all counties, with 10,000 NC citizens participating. Funded by Title X money, the campaign is administered by the NC Family Planning Board.

Contact person: Vicki Gerig
Family Planning Branch
P.O. Box 2091
Raleigh, NC 27602
Phone number: (919) 733-4871

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In January 1984, the State's Family Planning Branch and the Governor's Council on Children and Youth began implementing an initiative entitled "Postponing Sexual Involvement." The goal of this initiative is "to enable teens to better resist the pressures to begin sexual activity at an early age." Tapes, slides, and workbooks on peer pressure, assertiveness training, media treatment of sexuality, and other issues which influence teenagers' perceptions of sexuality are included in the curriculum. More than 200 community leaders have been trained in the curriculum, which is offered in more than 20 communities. County Health Department educators and nurses, youth leaders, youth agency directors, and school counselors are also involved.

North Carolina has also developed a plan to increase family involvement. Its objectives are "(1) to assure that all teenagers attending family planning clinics are counseled regarding the importance of communicating with parents about family planning needs; (2) to further the advocacy role of the Statewide Advisory Council network in promoting community understanding of the need for and importance of family involvement; and (3) to develop a mechanism to collect data regarding parent and community involvement activities at the local provider level."

In the Fall of 1984, the Department of Public Instruction began a Task Force on Teenage Pregnancy "to examine the current status of school-aged pregnant teenagers and teen mothers in an attempt to identify specific recommendations for program development aimed at addressing identified needs of this special school population."

State's response to survey submitted by:

The Honorable James G. Martin
Governor
State of North Carolina

NORTH DAKOTA

DEMOGRAPHICS

Total female adolescent population by age

	1980
10-14	24,715
15-17	17,741
18-19	13,316

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	9	7	7
15-17	424	394	293
18-19	1010	937	861

Number of abortions by age of mother

	1980	1983
10-14	2	5
15-17	44	106
18-19	89	313

Number of miscarriages by age of mother

	1978	1980	1983
10-14	0	0	1
15-17	1	4	4
18-19	9	8	5

HEALTH INDICATORS

Infant mortality rate by age of mother

	1978	1980	1982	1983
10-14	111.1	0.0	0.0	0.0
15-17	23.6	15.2	7.0	17.1
18-19	10.9	18.1	14.0	10.5

IMR for all births, 1983: 8.9

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	11.1%	0.0%	16.7%	0.0%
15-17	7.3	8.8	5.9	9.2
18-19	6.6	5.1	5.0	5.5

All low-birthweight births, 1983: 4.7%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	50.9%	59.7%	58.7%	60.6%

1983 rate for mothers, all ages: 81.5%

ECONOMIC INDICATORS

Adolescent unemployment rate

	1978	1980	1982	1983
Under 20	8.6%	9.1%	10.7%	8.8%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

1. Office of State Health Officer
   Health Department
   State Capitol, Judicial Wing, 2nd Floor
   Bismarck, ND 58505

Contact person: Dr. Robert M. Wentz, State Health Officer
Phone number: (701) 224-2372

2. Office of Executive Director
   Department of Human Services
   State Capitol, Judicial Wing, 3rd Floor
   Bismarck, ND 58505

Contact person: John Graham, Executive Director
Phone number: (701) 224-2310

Other offices and agencies with responsibilty for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Health Department (HD)

Preventive/Abstinence Education: HD

Maternal Health and Medical Care: HD

Perinatal Medical Care: HD

Infant/Child Health and Medical Care: HD

Educational and Vocational Assistance and/or Training: Job Service

Adoption Services: Department of Human Services (DHS)

Child Care: DHS

Evaluation: Legislature

PROGRAMS AND RESOURCES

1. Optional Pregnancy Outcome Projects. Directed at community health centers, these projects are jointly run by North Dakota's Departments of Health and Human Services, the March of Dimes Foundation, Fargo Community Health Center and Bismarck/Burleigh Nursing Services. The projects were designed to increase the availability and accessibility of prenatal and postpartum services to unmarried pregnant women. Prenatal education, nutritional education, pregnancy testing, counseling and referrals are provided. The projects began in November 1982, and are federally, State, and privately funded.

Contact person: Yvonne Kreth, Director
Bismarck Optional Pregnancy Outcome Project
409 West Front Avenue
Bismarck, ND 58501
Phone number: (701) 222-6525

2. Parenting/Outreach Project. Begun in July 1979, this initiative is directed at a maternity home. It is implemented by the North Dakota Department of Human Services, and the Luther Hall Maternity Home. The project is federally, State and privately funded.

Contact person: Mary Schafer, Director
Fargo Optional Pregnancy Outcome Project
Fargo Community Health Center
1241 2nd Street, N.
Fargo, ND 58102
Phone number: (701) 241-1370

3. Family Life Education Workshops. Implemented by the North Dakota Departments of Health and Human Services, this program began in September 1984. It is federally, State, and privately funded.

4. Women's Life Center. Run by the church in Grand Forks, this program is directed at individuals, community groups and schools. It is privately funded.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

The North Dakota Council on Problem Pregnancy was formed in 1980 "to develop a statewide approach to providing educational and treatment services to unmarried parents and their children." Representatives of State and community agencies participate on the Council. As part of its work, the Council and the Department of Human Services' Children and Family Services examined the provision of sexuality education in the State. The final report of this project, issued in February 1983, concludes that five needs appear to exist in the area of sex education:

(1) more parents need to be involved in sex education activities, as students;

(2) more parents, after having become students of sex education, need to become involved in the teaching of sex education;

(3) more sex education is needed in the primary grades;

(4) more sex education information is needed such as films, books, speakers, and workshops; and,

(5) more information should be geared to the general public to help illuminate the fact that there is real evident need for someone (parents, teachers, community agencies, clergy) to be responsible for providing the necessary information to the children and young adults of North Dakota.

State's response to survey submitted by:

Robert M. Wentz, M.D., State Health Officer
Department of Health

OHIO

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	375	N/A	N/A
15-19	26,416	26,140	23,006

Number of abortions by age of mother

	1978	1980	1983
10-14	248	N/A	N/A
15-19	10,913	10,798	11,651

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	15.5%	15.9%	16.6%	12.3%
15-19	10.0	9.3	9.2	9.7

All low-birthweight births, 1983: 6.7%

ECONOMIC INDICATORS

Adolescent unemployment rate

	1978	1980	1982	1983
16-19	14.9%	17.7%	27.5%	20.9%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Ohio Department of Health
246 N. High Street
Columbus, OH 43215

Contact person: David L. Jackson, M.D., Ph.D., Director of Health
Phone number: (614) 466-2253

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Ohio Department of Health (ODH), Planned Parenthood (PP) of Central Ohio, PP of Medina and Summit C

Sex Education: PP Affiliates of Ohio

Family Life Education: Department of Education (DOE)

Maternal Health and Medical Care: ODH

Perinatal Medical Care: ODH

Educational and Vocational Assistance and/or Training: DOE

Life Skills Development Training: DOE, Cooperative Extension

Adoption Services: Department of Human Services (DHS)

Child Care: DHS

PROGRAMS AND RESOURCES

1. Improved Pregnancy Outcome Program. This program is designed to enhance prenatal clinic programs for extended outreach and patient tracking. Outreach includes public education, primarily for adolescents, about responsible decision making, pregnancy, and the importance of early prenatal care. The State Health Department and 17 local health departments and community action organizations, funded through the Ohio Department of Health/Bureau of Maternal and Child Health, are involved in the implementation. The program began on November 1, 1979, with a Federal grant that has ended. The program has been continued.

2. Daytime Center for Girls (DCG). This program, designed for pregnant teens, offers social/educational services, individual and/or group counseling and on-site child care for postpartum mothers. The total annual caseload is approximately 200 girls. The program is implemented by the Family Service of Butler County. It operates in school and receives Federal funds, as well as funds from United Way and the Butler Mental Health Board. It began in 1981.

Contact person: Paula Bryant
Daytime Center for Girls
Family Life Educational Center
115 N. 6th Street
Hamilton, OH 45011

3. YWCA Young Mothers' Club. This is an after-school support group for pregnant teens and adolescent mothers at the local YWCA. It is federally and privately funded and began in 1983. There are about 15-20 girls in each session.

4. Marion Adolescent Pregnancy Program. This program offers support and education for pregnant teens as well as postpartum follow up for two years. Begun in 1980, this program is federally and privately funded. It is directed at public schools, has a referral mechanism with other local agencies, and has the co-operation of local OB/GYN doctors for clinical services.

Contact persons: Deborah Shade, Executive Director
Dr. James Bazzoli
240 E. Church Street
Marion, OH 43302
Phone number: (614) 387-8336

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5. Teenage Parents Program (TAP). TAP offers an evening-school program for pregnant teens that includes an academic program, prenatal education and parenting skills. Individual counseling is available and family members and boyfriends are involved. The program is implemented by the Family Service of Middletown and receives Federal and local funds. It began in 1976.

Contact person: Barbara Venters
Teenage Parents Program
Family Service of Middletown
29 City Center Plaza
Middletown, OH 45042

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1984, The Ohio State Health Department began a statewide promotion campaign entitled "Thanks Mom." This is a media initiative about the importance of early and regular prenatal care, aimed at schools, health service agencies, social service agencies and private physicians. In 1985 the campaign began addressing the prevention of fetal alcohol syndrome. More than 9,000 calls requesting information were received in the first year of the project. Materials are distributed where teens gather, with the assistance of local health/social service programs and schools. School health and family life education teachers incorporate the information into their curricula and often seek speakers from other maternal and child health projects in the area.

State's response to survey submitted by:

David L. Jackson, M.D., PH.D., Director
Department of Health

OKLAHOMA

DEOMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	114,443	112,047	108,452
15-19	131,620	134,860	139,720
15-17	76,849	77,960	79,626
18-19	54,771	56,900	60,094

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	147	146	148
15-19	9427	10,046	9866
15-17	3481	3593	3302
18-19	5946	6453	6564

Number of abortions by age of mother

	1983
10-14	104
15-19	3293
15-17	1172
18-19	2121

Number of miscarriages by age of mother

	1978	1980
10-14	3	3
15-19	88	95
15-17	36	36
18-19	52	59

Number of out-of-wedlock births by age of mother

	1978	1980	1983
10-14	107	121	126
15-19	2949	3198	3461
15-17	1450	1538	1596
18-19	1499	1660	1865

HEALTH INDICATORS

Infant mortality rate by age of mother*

	1978	1980	1982	1983
10-14	37.5	38.3	25.3	37.9
15-17	19.6	18.7	14.3	15.6
18-19	17.1	14.7	14.7	12.0

IMR for all births, 1983: 10.9
* Infant mortality reported as ratio of matched deaths to total deaths per 1000 live births.

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	13.6%	13.8%	15.0%	8.1%
15-17	9.2	9.3	8.9	9.4
18-19	8.8	8.1	8.4	7.9

All low-birthweight births, 1983: 6.7%

Percentage of live births to adolescent women who received prenatal care in the first trimester*

	1978	1980	1982
Under 20	51.5%	50.0%	49.1%

1983 rate for mothers, all ages: 67.4%
* Of those reporting.

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting tenagers

Maternal Child Health Services
State Department of Health
P.O. Box 53551
1000 N.E. 10th Street
Oklahoma City, OK 73152

Contact person: Marilyn Lanphier, M.P.H., Coordinator of Adolescent Services
Phone number: (405) 271-4476

Other offices and agencies with responsibility for the following activities for pregnant and parenting tenagers:

Preventive/Contraceptive Information and Services: Oklahoma State Dept. of Health (OSDH)

Preventive/Abstinence Education: OSDH

Family Life Education: Home Economics, State Dept. of Vocational Technical Education

Maternal Health and Medical Care: OSDH

Perinatal Medical Care: OSDH

Infant/Child Health and Medical Care: OSDH

Adoption Services: Division of Children and Youth, Dept. of Human Services

Evaluation: OSDH

New Programs and Policy Development: OSDH

PROGRAMS AND RESOURCES

1. **Oklahoma Governor's Advisory Committee on Children, Youth and Families.** This Committee operated from 1980 to 1982, and collected information, conducted in-depth studies, and provided data and recommendations to the Governor.

2. **Coalition on Adolescent Pregnancy and Parenting of Oklahoma.** Created in the fall of 1984, this coalition is comprised of State health officials and representatives from private organizations. They are currently planning a statewide conference.

3. **Adolescent Health Care Clinics.** The MCH service has developed these clinics in ten county health departments across the State. They provide adolescents with health promotion activities, health assessment, early identification of high-risk behavior, and intervention through treatment or referral.

Contact person: Marilyn Lanphier
Maternal and Child Health Service
Dept. of Health
P.O. Box 53551
1000 N.E. 10th Street
Oklahoma City, OK 73152
Phone number: (405) 271-4476

4. **Oklahoma Adolescent Health Project.** In 1982, the Robert Wood Johnson Foundation provided a grant to create this program. The objectives are to develop a rural-based consolidated health and mental health care program and to increase accessibility to this care.

Contact persons: Rebecca Beckman, M.D., Project Director
Byron Williams, Project Coordinator
Oklahoma Adolescent Health Project
OCMH
Room 4B-100
Oklahoma University Health Sciences Center
P.O. Box 26901
Oklahoma City, OK 73190

5. **"Dare To Be You."** This primary prevention program for pre-adolescents (8 to 12 years old), aims at reducing the risk of problem behaviors by developing skills to resist peer presure, building strong family support systems and improving communication skills.

Contact person: Marilyn Lanphier
Coordinator, Adolescent Services
Maternal and Child Health Services
OSDH
P.O. Box 53551
1000 N.E. 10th Street
Oklahoma City, OK 73152
Phone number: (405) 271-4476

6. Margaret Hudson Program. This program provides comprehensive services to pregnant and parenting adolescents in Tulsa County. It consistes of four components; academics, health education, counseling and enrichment.

7. Pauline Mayer Group Home. This is a residential facility operated by the Department of Human Services for teenage mothers in the Department's legal custody. It promotes parenting and self-living skills, and provides an opportunity for continued education.

Contact person: Barbara York
Pauline Mayer Group Home
1201 NW 12th Street
Oklahoma City, OK 73117
Phone number: (405) 271-7606

8. TEAM Program. This program is run by the Moore Public Schools for pregnant adolescents, and provides education with individual referrals for medical and financial help.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

There have been recent policy changes in sex education and child care. With regard to these changes, the survey refers to House Bill 1468 (1982), revising the State's Children's Code.

State's response to survey submitted by:

Joan K. Leavitt, M.D., Commissioner of Health
Department of Health

PENNSYLVANIA

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	478,000	455,681	426,300
15-19	522,100	535,400	498,200
15-17	N/A	312,058	N/A
18-19	N/A	223,342	N/A

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	359	326	363
15-19	21,828	21,749	20,259
15-17	7840	7537	7215
18-19	13,988	14,212	13,044

Number of abortions by age of mother

	1978	1980	1983
10-14	642	662	592
15-19	18,931	19,540	16,649
15-17	7867	8020	6832
18-19	11,064	11,520	9817

Number of miscarriages by age of mother

	1978	1980	1983
10-14	10	13	5
15-19	368	346	294
15-17	141	140	117
18-19	227	206	177

Total number of female parenting adolescents

	1982
Under 20	40,402

HEALTH INDICATORS

Infant mortality rate by age of mother*

	1980
10-14	43.2
15-17	17.1
18-19	14.5

IMR for all births, 1983: 11.3

* Rates are for single live births.

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	16.2%	14.5%	12.7%	20.1%
15-19	9.7	9.5	9.9	9.6

All low-birthweight births, 1983: 6.7%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	53.7%	53.8%	52.5%	49.9%

1983 rate for mothers, all ages: 79.0%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1978-79	1979-80	1981-82
Under 20	12,379	12,043	11,135

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	March 1979	March 1983
Under 20	13,524	11,092

Adolescent unemployment rate

	1978	1980	1982	1983	1984
16-19	18.0%	19.9%	23.3%	23.9%	20.0%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Governor's Office of Policy Development
P.O. Box 1323
506 Finance Building
Harrisburg, PA 17105

Contact person: Martha Bergsten, Executive Policy Specialist
Phone number: (717) 787-1954

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Office of Children, Youth and Families (OCYF), Dept. of Public Welfare (DPW)

Sex Education: Dept. of Education (DOE)

Family Life Education: DOE

Maternal Health and Medical Care: Maternity Program, Division of Maternal/Child Health, Dept. of Health (DOH)

Perinatal Medical Care: Maternity Program, Division of Maternal/Child Health, DOH

Infant/Child Health and Medical Care: Child Health Program, Division of Maternal/Child Health

Educational and Vocational Assistance and/or Training: Dept. of Labor and Industry

Life Skills Development Training: DOE

Adoption Services: OCYF, DPW

Child Care: OCYF, DPW

New Programs and Policy Development: Gov. Office of Policy Development

PROGRAMS AND RESOURCES

1. Allen High Interim School. Begun in 1970, this is one of the oldest programs for pregnant teens in the State. It provides free and individualized educational services and child care, and is now incorporated into a regular high school.

Contact person: Robert Klova
Director Middle/Senior High
Allentown City School District
Box 328
31 South Penn Street
Allentown, PA 18105

2. Altoona Area High School, School-Age Parent Program. Offered free of charge, this program gives pregnant and parenting adolescents a chance to complete their high school education and gain parenting skills. The program is part of the Department of Home Economics, and has received vocational education funds. Child care is provided on-campus.

Contact person: Walter Betar, Principal
Altoona Area High School
6th Avenue and 13th Street
Altoona, PA 16602
Phone number: (814) 946-8204

3. Elm Program for Pregnant Students. This program teaches parenting skills and child development, provides counseling, and coordinates with community services. Organized as a separate program in 1969, it is now housed in regular schools.

Contact person: Mattie Sue Brown
Elm Program Coordinator
Harrisburg School District
Box 2645
Harrisburg, PA 17105
Phone number: (717) 255-2507

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Pennsylvania, under the "Governor's Improved Services to Teenage Parents and Pregnant Teenagers 1985-86 Initiative," has provided over $4 million (slightly more than half in State funding; half in Federal support) for new education, job training, day care and health care services that build on ongoing programs and services.

The initiative focuses on several areas, including:

-- A Competitive Grant Program for Public Schools, which will provide funding to schools on a competitive basis to establish comprehensive programs for pupils who are either pregnant or who are already parents. An appropriation of $1,846,000 was proposed, $946,000 from the General Fund and $900,000 from federal Vocational Education funds.

-- A Competitive Grant Program to Private Industry Councils (PICs), which will provide funds to PICs to establish job training programs designed to meet the needs of eligible pregnant teenagers and teen parents. The PICs will match State funds with JTPA funds.

Prenatal care for adolescents will also be expanded, as will efforts to prevent fetal alcohol syndrome and fetal alcohol effects. A toll-free Teen Parents hotline will be established, as well, to encourage newly pregnant teens to seek help early on, and to provide information and referral services to teenagers in all stages of pregnancy and parenthood.

Pennsylvania also reported recent policy changes regarding parental notification and abortion services. Under the "Abortion Control Act of 1982," parental consent or judicial permission must be granted before an abortion may be performed on adolescents less than 18 years old.

State's response to survey submitted by:

Martha Bergsten
Governor's Office of Policy Development

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RHODE ISLAND

DEMOGRAPHICS

Total female adolescent population by age

	1980
10-14	36,205
15-19	45,002

Number of births to teenagers by age of mother

	1979	1980	1982
10-14	17	18	11
15-19	1479	1481	1399
15-17	467	423	459
18-19	1012	1058	940

Number of abortions by age of mother

	1979	1980	1982
10-14	21	14	25
15-19	1286	1475	1432
15-17	342	438	501
18-19	944	1037	931

Number of miscarriages by age of mother

	1979	1980	1982
10-14	2	1	3
15-19	82	66	58
15-17	26	25	20
18-19	56	41	38

HEALTH INDICATORS

Neonatal mortality rate by age of mother*

	1976-1982
Under 14	25.2
15-17	12.4
18-19	10.8

IMR for all births, 1983: 11.7

* Neonatal mortality rate reported as per 1000 live births

Percentage of births to teenagers which are low birthweight

	1979	1980	1982	1983
Under 14	11.8%	16.7%	9.1%	11.1%
15-17	8.6	7.8	10.0	11.5
18-19	9.0	8.5	7.2	9.5

All low-birthweight births, 1983: 6.4%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1976-1982
Under 20	65.7%

1983 rate for mothers, all ages: 84.7%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Division of Community Services Planning Office
Department of Social and Rehabilitative Services
600 New London Ave.
Cranston, RI 02920

Contact person: Dawn E. Sullivan, Assistant Director
Phone number: (401) 464-2423

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Family Health, Rhode Island Department of Health (RIDH)

Preventive/Abstinence Education: Family Planning

Sex Education: Dept. of Education (DOE)

Family Life Education: DOE

Maternal Health and Medical Care: Family Health, RIDH

Perinatal Health: Family Health, RIDH

Infant/Child Health and Medical Care: Family Health, RIDH; Dept. of Social and Rehabilitative Services (SRS)

Educational and Vocational Assistance and/or Training: DOE

Life Skills Development Training: DOE

Adoption Services: Dept. of Children and Their Families (DCTF)

Child Care: DCTF

Evaluation: Advisory Committee for Adolescent Projects, SRS

New Programs and Policy Development: SRS

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1985 the Department of Social and Rehabilitative Services began a $280,000 grant program, the Adolescent Pregnancy-Parenting Program, to provide comprehensive services to pregnant and parenting teenagers though a "case managed service delivery system." In this program, the Department purchases services from seven community providers, and the services are offered in a variety of settings, including two in-school settings.

Services provided under this program include health care, education, social services, housing services, and training and employment. The Rhode Island Directorate of Children, composed of the five major State departments with a mandate to serve children (Health; Education; Children and Their Families; Mental Health, Retardation and Hospitals; and, Social and Rehabilitative Services), the State Budget Office, and a community children's advocate, the Southeastern New England United Way, assist in funding this effort.

The survey noted policy changes in the areas of sex education, parental involvement, and maternal health and medical care. No description of these changes was provided.

State's response to survey submitted by:

The Honorable Edward D. DiPrete
Governor
State of Rhode Island

SOUTH CAROLINA

DEMOGRAPHICS

Total female adolescent population by age

	1980	1982
10-14	130,702	131,637
15-19	154,126	153,040

Number of births to teenagers by age of mother

	1978	1980	1982
10-14	347	287	261
15-19	10,083	9941	9280
15-17	4125	4003	3540
18-19	5958	5938	5740

Number of abortions by age of mother

	1978	1980	1982
10-14	155	150	151
15-19	3404	4080	3681
15-17	1594	1810	1559
18-19	1810	2270	2122

Number of fetal deaths by age of mother

	1980	1982
10-14	6	1
15-19	137	146
15-17	N/A	61
18-19	N/A	85

HEALTH INDICATORS

Infant mortality rate by age of mother

	1980	1982
Under 15	55.7	23.0
15-19	23.3	22.8

IMR for all births, 1983: 15.0

Percentage of births to teenagers which are low birthweight

	1978	1980	1982
10-14	19.0%	17.0%	15.0%
15-19	12.0	12.0	13.0

All low-birthweight births, 1983: 8.6%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

None.

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: South Carolina Dept. of Health and Environmental Control (SCDHEC)

Maternal Health and Medical Care: SCDHEC

Infant/Child Health and Medical Care: SCDHEC

PROGRAMS AND RESOURCES

1. Teen Pregnancy Reduction Network. (See Statewide Initiatives.)

Contact person: Ruth Martin
Health Education Consultant
Office of Health Education
S.C. Dept. of Health and Environmental Control
2600 Bull St.
Columbia, SC 29201
Phone number: (803) 758-5555

2. "Teen Pregnancy in South Carolina: Everbody's Problem." The first volume has been completed, and includes recommendations, statistics, public-sector costs of teenage pregnancy, and a description of programs and services. (See Statewide Initiatives.)

Contact person: Peter Lee
Planning and Evaluation Consultant
Office of Health Education
SCDHEC
2600 Bull St.
Columbia, SC 29201
Phone number: (803) 758-5555

3. Comprehensive Adolescent System of Health (CASH) Project. This project includes an in-school adolescent health care program, affiliated health services at a local hospital, prevention-oriented education, and linkage between existing social services. The Richland County demonstration program is aimed at preventing unwanted pregnancy and minimizing the risks of adolescent pregnancy and parenting.

4. Facts of Life. In October 1984, the Division of Maternal Health, South Carolina Department of Health and Environmental Control (SCDHEC), assembled and distributed this package of parent-education materials enabling parents to be better prepared to communicate with their children about sexuality.

6. Teen Companion Program. The goal of this program is to reduce the rate of teenage pregnancies in families receiving AFDC, thus reducing the public cost of support to second generations of these families. The methodology of the Teen Companion Program is one which seeks to change behavior through intensive educational, health, and emotional services mediated through para-professional adult and teen companions supported by professional training, supervision, and counsel. The program is administered by the SC Department of Social Services and a services coordinator for each county or group of counties.

Contact person: Leo Richardson, Ph.D.
Special Assistant to the Commissioner
State Department of Social Services
P.O. Box 1520
Columbia, S.C. 29202
Phone Number: (803) 752-3027

8. Adolescent Pregnancy Child Watch Project. A community-level effort to gather and disseminate information on teen pregnancy. The effort is supported by a group of non-profit agencies and utilizes volunteer help.

Contact persons: Mrs. Sarah Leanord
Convenor
S.C. State Mechanism/HCHW
11 Captiva Row
Charleston, S.C. 29407

Dr. Alma Byrd, S.C.
Coordinator for
Adolescent Pregnancy
Child Watch Project
2327 Willow Street
Columbia, S.C. 29204

9. "Speaking the Truth in Love." Published in May 1985, this manual on teenage pregnancy and the black family is by the Baptist Educational and Missionary Convention, for use by churches and other interested groups.

Contact person : Baptist Educational and Missionary Convention
2334 Elmwood Avenue
Columbia, S.C. 29204
Phone number: (803) 254-5859

10. "Postponing Sexual Activity." 51 staff members from all health districts in the State, were trained to use these materials which were developed at Emory University in workshops with parents and teenagers.

11. Delta Sigma Theta sorority. The sorority's theme project, focusing on the black family, has spawned conferences since April 1985, and a task force.

12. Resource Mothers Project. This is a support program for pregnant teenagers which has been successful at reducing the rate of low-birthweight births. SCDHEC, Division of Maternal Health received a three-year Special Project grant in the Fall of 1985 to expand the program.

13. Conference on Effective School-based Sexuality Education Programs. Hosted by the State Department of Health Education and State agencies, this conference discussed the teen pregnancy situation and effective school-based clinic models.

14. Adolescent Reproductive Risk Reduction (3R) Curriculum. This public school currriculum is supported with a three-year Special Project grant awarded to SCDHEC, Department of Health Education.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

The "Teen Pregnancy Reduction Network" was established in December 1984, by black leaders to reduce teen pregnancy and its effects on black families. The "Network" is composed of leaders of several black organizations, the State Department of Social Services, and the Governor's Office. The "Network" has helped to sponsor conferences and workshops and to plan teen pregnancy prevention targeted to teen children of mothers receiving AFDC. The "Network" also publishes a quarterly newsletter covering national, State and local efforts.

On October 17, 1985 the Governor signed an Executive Order creating a Statewide Task Force on Prevention of Teenage Pregnancy "to develop a comprehensive plan for a coordinated statewide approach to the prevention of teenage pregnancy." The Task Force is scheduled to report to the Governor by May 1986.

The South Carolina Department of Health and Environmental Control is preparing to issue Volume II of the report, "Teenage Pregnancy in South Carolina: Everybody's Problem." The initial report, published in 1983, includes several recommendations. A preliminary draft of Vol. II of the report includes more detailed data, as well as possible approaches for the prevention of teenage pregnancy. It also provides nearly 20 recommendations for the "primary prevention of teenage pregnancy" and for "secondary prevention of the sequelae of teen parenthood." They include:

Primary prevention

- -- develop a State Pregnancy Prevention Plan which addresses issues of policy, coordination and adequacy of services;
- -- provide state funding for comprehensive family life and reproductive health education in grades K-12;
- -- develop policies and programs that encourage girls to participate in meaningful vocational education;
- -- increase the efforts being made to provide job opportunities and community volunteer activities for youth;
- -- provide innovative alternative education programs, targeted to poorer communities and those with high dropout rates;
- -- establish school-based comprehensive health services for adolescents which meet basic health needs of teens and provide counseling and referral as needed;
- -- identify pre-teens at high risk for pregnancy and direct intervention efforts to them before they become sexually active;
- -- focus teen pregnancy prevention on young males;
- -- direct pregnancy prevention programs toward the syndrome nature of teen problem behaviors;
- -- increase the number and scope of health education programs in schools, youth agencies, churches, health care agencies, and on television and radio;
- -- relax restrictions on distribution and advertising of nonprescription contraceptives;
- -- include health education reproductive risk reduction objectives and skills in the Basic Skills Assessment Program for 8th and 11th grade;
- -- support the DSS sponsored "Teen Companion Program," which is a project aimed at reducing teenage pregnancies in AFDC households;
- -- join the Teen Pregnancy Reduction Network;

Secondary prevention

- -- coordinate assistance programs;
- -- include family planning, prenatal care, and well-baby care in comprehensive health care for teens;
- -- make early pregnancy testing available from school nurses in middle and high school;
- -- increase educational and outreach efforts to promote earlier entry to prenatal care for pregnant teens.

The draft report also mentions a number of county and local initiatives on the adolescent pregnancy issue, including workshops, trainings, and local coalition activities.

State's response to survey submitted by:

The Honorable Richard W. Riley
Governor
State of South Carolina

SOUTH DAKOTA

DEMOGRAPHICS

Total female adolescent population by age

	1980
10-14	26,647
15-19	34,025
15-17	19,621
18-19	14,404

Number of births to teenagers by age of mother

	1978	1980	1983
15-19	1817	1790	1459
15-17	N/A	535	409
18-19	N/A	1255	1050

Number of abortions by age of mother

	1978	1980	1983
15-19	524	475	518
15-17	N/A	187	211
18-19	N/A	288	307

Number of miscarriages by age of mother

	1980	1983
15-19	14	10

HEALTH INDICATORS

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1983
Under 20	51.4%

1983 rate for mothers, all ages: 72.1%

ECONOMIC INDICATORS

Number of pregnant and parenting adolescents receiving AFDC

	1978	1980	1982	1984
16-20	680	738	441	402

Adolescent unemployment rate

	1978	1980	1982	FY 1983
Under 20	5.9%	8.5%	12.0%	14.8%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Maternal and Child Health
Division of Health Services
Department of Health
523 E. Capitol
Pierre, SD 57501

Contact person: Sandra K. Durick, Program Director
Phone number: (605) 773-3737

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Family Planning Program, Dept. of Health (FPP/DOH)

Preventive/Abstinence Education: FPP, DOH

Maternal Health and Medical Care: Maternal and Child Health (MCH) Program, DOH

Perinatal Medical Care: MCH Program, DOH

Infant/Child Health and Medical Care: MCH Program, DOH

Educational and Vocational Assistance and/or Training: Department of Vocational Education

Adoption Services: Department of Social Services (DSS)

Child Care: DSS

PROGRAMS AND RESOURCES

1. Methodist Hospital. This community hospital runs a variety of programs including parenting education, child care, and in-service education. It has also established a support center for parents who have lost a child. These programs, begun in October 1983, receive Federal and private funds, and involve the Department of Health.

2. Positive Parent Network. The Department of Health is involved in implementing these educational programs which are run out of a community education center. Initiated October 1984 with Federal and private money, the network provides teenage parenting education, support sessions, childbirth education, and child care.

3. Indian Health Management, Inc. This organization provides prenatal education, postpartum visits, well-child visits, and transportation to the Rosebud reservation. They receive Federal and private funds for salaries for MCH outreach workers. The program started in October 1984.

4. Lower Brule Sioux Tribe. Begun in 1983, this program provides health education, prenatal education and well-child visits. It receives Federal and private funds.

5. MCH block grant, and Title X funds are used to fund a variety of parenting classes around the State.

__State's response to survey submitted by__:

Timothy R. Koehn, Program Administrator
Children, Youth, and Family Services, Department of Social Services

TENNESSEE

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	184,292	180,538	175,221
15-19	204,887	210,756	201,859
15-17	122,245	124,761	118,829
18-19	82,642	85,995	83,030

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	359	291	272
15-19	13,830	13,468	11,557
15-17	5596	5349	4292
18-19	8234	8119	7265

Number of abortions by age of mother

	1978	1980	1983
10-14	199	234	229
15-19	4790	5673	5039
15-17	1824	2201	1925
18-19	2966	3472	3114

Number of out-of-wedlock births by age of mother

	1978	1979	1980	1981	1982
10-14	292	268	248	260	249
15-19	5569	5687	5729	5583	5461

HEALTH INDICATORS

Infant mortality rate by age of mother*

	1978	1980	1982	1983
Under 15	61.3	27.5	24.0	55.1
15-17	23.1	18.5	20.7	18.6
18-19	19.3	16.3	15.8	18.3

IMR for all births, 1983: 12.8

* IMR reported as per 1000 live births age specific.

Percentage of births to teenagers which are low birthweight*

	1978	1980	1982	1983
10-14	15.0%	13.7%	13.4%	12.9%
15-17	11.4	11.3	11.7	11.2
18-19	10.2	10.1	10.1	10.1

All low-birthweight births, 1983: 8.0%

* LBW reported as a percent of live births age specific.

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	49.5%	53.8%	51.3%	51.6%

1983 rate for mothers, all ages: 74.7%

ECONOMIC INDICATORS

Adolescent unemployment rate

	1980	1982	1983	1984
16-19	20.8%	34.3%	28.5%	25.8%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

General services: Children Service Commission
1600 Kames K. Polk Building
Nashville, TN 37219

Contact person: Karen Edwards, M.D., Executive Director
Phone number: (615) 741-2633

MCH services: Reproductive Health Services
Natural and Child Health
Department of Health and Environment
100 Ninth Avenue North
Nashville, TN 37219-5405

Contact person: Ms. Margaret F. Major, Director
Phone number: (615) 741-7335

Social Services: Parenting and Placement Service
Department of Human Services
111 Seventh Avenue North
Nashville, TN 37203

Contact person: Miss Bertalee Quary, Program Specialist III
Phone number: (615) 741-5938

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Department of Health and Environment (DHE)

Preventive/Abstinence Education: DHE

Maternal Health and Medical Care: DHE

Perinatal Medical Care: DHE

Infant/Child Health and Medical Care: DHE

Educational and Vocational Assistance and/or Training: Dept. of Education

Adoption Services: Dept. of Human Services (DHS)

Child Care: DHS

PROGRAMS AND RESOURCES

1. Crittenton Services of Nashville. This private, non-profit agency provides support services to pregnant teenagers, expectant fathers, and teen parents and their families, through a multi-faceted community-based program. The services include school-based counseling, community-based counseling, telephone information and referral, case advocacy, and training.

Contact person: Mrs. Amy Kemmer, Executive Director
Phone number: (615) 255-2722

2. Rule High School. This school sponsors a day care program for teenage parents who take turns caring for the children.

Contact person: Lynn Overholt
Rule High School
1919 Vermont Ave.
Knoxville, TN 37921
Phone number: (615) 525-2892

3. Consortium on Adolescent Pregnancy and Parenthood (CAPP). A group of agencies based in Nashville meet monthly to share information and to plan ways to better educate the community on the problems of teenage pregnancy. They have published a brochure, "Teenage Pregnancy: Cause for Concern."

Contact: CAPP
P.O. Box 15247
Nashville, TN 37213

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Tennessee began the "Governor's Healthy Children's Initiative" in 1983. It is chaired by the First Lady and includes the Departments of Health and Environment, Human Services, Mental Health and Retardation, and Education; the Children's Services Commission; and various other public and private agencies. It is a four-year program designed to promote healthy development among the children of the State. Although no funds were specifically earmarked for teen pregnancy efforts, the Initiative's components directly address many of the problems of adolescent pregnancy.

In its first year, the initiative focused on expanding prenatal care, networking, and increasing public awareness on these issues. A toll-free telephone line is publicized in public schools, advising adolescents who are pregnant or think they are pregnant to call. Adolescents are provided information, and referrals are made as needed and appropriate.

The initiative will also concentrate on developing a systematic and effective mechanism for identifying high-risk infants and ensuring that services are received. The final year of the initiative will examine school health and develop models for providing health education and health services in the schools. Parents and churches are encouraged to support family life education. The Department of Health and Environment has primary responsibility for implementing the initiative.

Tennessee noted policy changes in parental involvement, involvement of father, adoption services and counseling, and maternal health and medical care. The State's prenatal care program, founded in 1982, has emphasized services to high-risk groups, including teenagers. With regard to adoption, Tennessee has focused on seeking families who are willing to adopt teenagers and preparing teens for possible placement. The State has also emphasized increased involvement of all biological parents in decision-making and creating greater public awareness concerning the availability of adoption services. Also, a "putative father registry" has been established.

State's response to survey submitted by:

Rachel Touchton, Assistant Commissioner for Social Services
Department of Human Services

TEXAS

DEMOGRAPHICS

Total female adolescent population by age

	1984
10-14	1,264,941
15-19	1,363,962

Number of births to teenagers by age of mother

	1981	1984
Under 20	50091	46987
Under 12	2	1
12	26	27
13	154	197
14	816	863
15	2888	2616
16	5954	5616
17	9729	8886
18	13,502	12,590
19	17,020	16,193

Number of not married female adolescent parents by age

	1970	1981	1982	1984
Under 20	11,099	16,780	17,512	17,650
Under 12	N/A	1	N/A	1
12	N/A	25	N/A	23
13	N/A	138	N/A	175
14	N/A	557	N/A	592
15	N/A	1633	N/A	1517
16	N/A	2703	N/A	2800
17	N/A	3624	N/A	3678
18	N/A	4034	N/A	4334
19	N/A	4065	N/A	4530

PROGRAMS AND RESOURCES

1. Three State agencies sponsor the major health and human services programs which most directly affect adolescent parents. The Texas Department of Health, the Texas Department of Human Services and the Texas Education Agency administer these federally and State-supported programs throughout the State.

2. The Texas Education Agency serves pregnant adolescents through its general special-education component.

3. There is one State-sponsored transportation program which is partially funded through the Social Services Block Grant. This effort transports teenagers to sites where services are located.

4. Teen Parent Self-Sufficiency Program. The Department of Human Services, the Department of Health, the Department of Mental Health and Mental Retardation, and the Department of Community Affairs/JTPA (Job Training Partnership Act) are involved in this pilot project specifically designed to meet the needs of the pregnant adolescent. The program focuses on the needs of teen parents in health, education and employment preparation.

5. "The Final Report on Adolescent Pregnancy and Teen Parents." (See Statewide Initiatives.)

Contact person: Audrey A. Arechiga, M.S.S.W.
Planning Assistant
Texas Health and Human Services
Coordinating Council
P.O. Box 12428
Austin, TX 78711

6. Education for Parenthood. Located in Austin Independant School District (AISD), this program was originally funded in 1976 by Title IV-C. The program is open to male and female students. The curriculum is designed to enhance the quality of family life through the development of parenting skills. Courses in homemaking, child development, and physical and reproductive health are included. In 1981, 2,500 male and female students participated. Incorporated in Education for Parenthood are Infant and Family Development Centers. Located on four school campuses, these centers serve infants and children. They also serve as day care facilities for school-age parents in the district.

7. Kealing Teenage Parent Program (AISD). This program served 194 students in the 1979-1980 school year. In addition to the regular academic curriculum provided at the school, individual counseling, education on child development, vocational education, child abuse prevention, and health and nutrition were offered. Included in this program was the Kealing Infant Development Center where there was space for 30 infants. The Infant Center is operated on a contract basis by Child, Inc., a federally funded child care agency in Austin.

8. New Lives. A comprehensive program for pregnant teens in the Ft. Worth Independant School District.

9. The TX Department of Human Resources purchases day care services for certain low-income families through Title XX and Child Protective Services. In addition to the school-aged parents who may have used Title XX purchased day care services in community-based centers, the Child Protective Services division had contracts with four day care centers providing care for the babies of unmarried school-age mothers. These contracts were located in Amarillo, Nacogdoches, El Paso, and Ft. Worth. With the exception of the Amarillo center, these centers were located on school campuses for pregnant teens. In 1981, 1,238 unmarried teen mothers utilized these services. 75 percent of the funds used were Federal.

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

The Select Committee on Teenage Pregnancy, created in the Sixty-Seventh Legislature, presented its final report to the Legislature in 1982.

Since then, several developments have affected services to pregnant and parenting adolescents. The Texas Health and Human Services Coordinating Council was formed at the request of the legislature in 1983 to examine and evaluate services for children. In October 1985, the Council issued a "Final Report on Adolescent Pregnancy and Teen Parents." This Report describes the present service system for the population, identifies those recommendations of the Select Committee that have not yet received consideration, and presents recommendations for the future.

The recommendations "focus on the need for interagency planning and cooperation to serve this population," and include:

1. That the Texas Health and Human Service Coordinating Council (THHSCC) and program staff from the Department of Community Affairs (TDCA), the Texas Education Agency (TEA), the Department of Health (TDH), the Department of Human Services (TDHS), the Department of Mental Health and Mental Retardation (TDMHMR), and the Texas Youth Commission (TYC), develop a three-year plan for prevention efforts and program development for adolescent pregnancy. This plan should take into account the need for transportation and day care in order to make it possible for pregnant teens and teen parents to obtain services. This plan should be completed and endorsed by the agencies by June of 1986.

2. That the Council work with TEA staff on a study of the effectiveness of present education alternatives for pregnant teenagers and teen parents. The report should include demographic data, geographic distribution, dropout rates, costs per student, feasibility of school-based day care programs, and recommendations for funding changes.

3. That the Council work with TEA curriculum staff in gathering information from Texas and other states regarding comprehensive reproductive, family life, and parenting edcuation programs in schools. This should lead to the development of recommendations to be presented to the State Board of Education for its consideration. An effort should be made to enlist the help of private organizations, and should include a review of the literature in this area.

4. That the agency representatives and THHSCC staff, described in Recommendation 1, investigate the feasibility of developing a "Teenline." This group should develop a final report which will include a proposal for the administration and operation of the "Teenline" and a breakdown of costs and resources needed to implement the information and referral component. The report should be prepared for Council consideration by June 1, 1986. At this time, a decision would be made whether to work toward implementing the plan.

5. That a follow-up report on the status of services to the above populations be completed and presented to Council and other interested parties by September 1, 1987.

The report also cites two recent legislative changes: the passage of the "Indigent Health Care Legislative Package" and approval of an increased average grant for recipients of Aid to Families with Dependent Children.

State's response to survey submitted by:

Audrey A. Arechiga, M.S.S.W., Planning Assistant
Texas Health and Human Services Coordinating Council

UTAH

DEMOGRAPHICS

Teenage fertility rate*

	1978	1979	1980
15-19	62	64	65

* TFR reported as per 1000 live births.

Abortion rate for white females by age

	1978	1979	1980	1981
15-17	6.0	8.0	8.6	7.7
18-19	16.0	17.9	17.8	18.9

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Family Health Services
Department of Health
44 Medical Drive
Salt Lake City, UT 84113

Contact person: Peter C. van Dyck, M.D., M.P.H., Director
Phone number: (801) 533-6161

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Maternal Health and Medical Care: Department of Health (DOH)

Perinatal Medical Care: DOH

Infant/Child Health and Medical Care: DOH

Educational and Vocational Assistance and/or Training: Department of Education

Adoption Services: Department of Social Services (DSS)

Child Care: DSS

PROGRAMS AND RESOURCES

1. Y-Teen Home. This is a program of the YWCA, which provides residential care for pregnant teens under age 19 during the last half of their pregnancies, and up to three months postpartum (if the mothers choose to keep their infants). The home opened in May 1982.

Contact person: Stephanie Velsmid
YWCA
322 East Third Street
Salt Lake City, UT 84111
Phone number: (801) 355-2804

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Policy changes have been made in; provision of contraceptive services, sex education, parental notification/consent, parental involvement, abortion counseling, and abortion services. No description of these changes was provided.

State's response to survey submitted by:

Thomas J. Wells, M.D., M.P.H., Director
Maternal and Infant Health Bureau, Department of Health

VERMONT

DEMOGRAPHICS

Total female adolescent population by age

	1978	1980	1983
10-14	21,548	20,720	19,751
15-19	25,618	25,735	23,309
15-17	14,064	14,033	12,262
18-19	11,554	11,702	11,047

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	9	8	7
15-19	879	992	844
15-17	301	289	242
18-19	578	703	602

Number of abortions by age of mother

	1978	1980	1983
10-14	10	18	9
15-19	591	743	640
15-17	205	255	249
18-19	386	488	391

Number of fetal deaths by age of mother

	1978	1980	1983
10-14	0	0	0
15-19	7	14	4

HEALTH INDICATORS

Infant mortality rate by age of mother

	1978	1980	1982	1983
Under 15	0.0	0.0	0.0	0.0
15-17	29.9	24.2	25.1	12.4
18-19	20.8	14.2	17.3	8.3

IMR for all births, 1983: 8.7

Percentage of births to teenagers which are low birthweight

	1979	1980	1982	1983
10-14	22.0%	25.0%	20.0%	14.0%
15-17	10.0	11.0	8.0	5.0
18-19	8.0	6.0	7.0	6.0

All low-birthweight births, 1983: 5.9%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	57.0%	59.0%	62.0%	64.0%

1983 rate for mothers, all ages: 82.9%

ECONOMIC INDICATORS

Number of teenage mothers receiving Aid to Needy Families and Children

Age	April 1984	January 1985
13-19	442	413
13	1	1
14	0	2
15	10	5
16	24	24
17	62	51
18	143	135
19	202	195

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Agency of Human Services
Office of the Secretary
103 South Main St.
Waterbury, VT 05676

Contact person: Stephen F. Chupack, Staff Assistant to the Secretary
Phone number: (802) 241-2220

Other offices and agencies with responsibility for the following activities:

Maternal Health and Medical Care: Department of Health (DOH)

Perinatal Medical Care: DOH

Infant/Child Health and Medical Care: DOH

Educational and Vocational Assistance and/or Training: Department of Education

Adoption Services: Department of Social and Rehabilitation Services

Evaluation: Division of Planning, Agency of Human Services

New Programs and Policy Development: Office of the Secretary, Agency of Human Services

PROGRAMS AND RESOURCES

1. Family Support Day Care Services. This two-year, State-funded program began in 1984. It is operated by the Department of Social and Rehabilitation Services, and targets "at-risk" families for regulated day care services.

2. Family Support Program. This program was created in 1984 , and will run for two years. It receives State funds, and is operated by the Department of Social and Rehabilitation Services, the University of Vermont, and 12 local agencies. The program provides short-term, in-home skill building services for parents "at risk."

3. Parent-Aid Program. This federally funded program, created in 1980, was in operation for four years. It was run by various local agencies which aimed at developing parenting services in private agencies.

4. Healthy Start. This program teaches parenting skills to first-time pregnant women in the White River and Springfield Health Department districts, and is administered by the Agency of Human Services. Women are divided into two groups; one receives bi-weekly structured home visits, the other receives the home visits, but also participates in bi-weekly structured support groups following birth. Trained public health nurses are responsible for delivering services.

5. Hand in Hand and Partners for Growth. The Agency of Human Services, with foundation support, is operating two demonstration programs also designed to provide at-risk families (including adolescents) with intense home visiting, support groups, and parent education/training. Para-professionals with nurse supervision provide the services. The major objectives are improvement in parenting skills, the parent/child relationship, and child development.

6. The Single Parent Opportunity Program (SPOP). The Vermont Department of Social Welfare has implemented this program which is designed to provide services and training opportunities to single parents who have at least one child under six and are receiving Aid to Needy Families and Children (ANFC).

7. Bennington Teenage Pregnancy Project. This project, started in 1984, is supported with Health Department funds, and coordinated through the Secretary's Office in the Agency of Human Services. Its primary purpose is to provide coordinated case services for pregnant girls, age 19 and under in Bennington. Approximately 32 girls are participating. A Teen Pregnancy Counselor, Kristin Williams Propp, is employed to work with State agencies, and local social service and health providers.

8. Addison County Parent/Child Center. This center runs a variety of programs for pregnant and parenting teenagers. It receives Federal, State, local, and private funding.

Contact: Addison County Parent/Child Center
Box 646
Middlebury, VT 05753
Phone number: (802) 388-3171

State's response to survey submitted by:

Stephen F. Chupack, Staff Assistant
Agency of Human Services

287

VIRGINIA

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	275	231	234
15-19	11,953	11,889	10,500
15-17	4527	N/A	3565
18-19	7426	N/A	6935

Number of abortions by age of mother

	1978	1980	1983
10-14	378	375	354
15-19	9319	9358	8378
15-17	4018	N/A	3578
18-19	5301	N/A	4800

Number of fetal deaths by age of mother

	1978	1980	1983
10-14	36	32	15
15-19	935	815	739
15-17	360	N/A	260
18-19	575	N/A	479

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1979	1980	1982	1983
10-14	16.0%	15.0%	16.0%	17.0%
15-19	11.0	11.0	10.0	10.0

All low-birthweight births, 1983: 7.2%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1979	1980	1982	1983
Under 20	33.0%	33.0%	32.0%	31.0%

1983 rate for mothers, all ages: 80.6%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1978	1980	1982	1983
Under 20	9795	9000	7994	7381

ECONOMIC INDICATORS

Adolescent unemployment rate

	1978	1980	1982
Under 20	17.6%	13.8%	20.0%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Division for Children
805 E. Broad Street
Richmond, VA 23211

Contact person: Martha Norris-Gilbert, Director
Phone number: (804) 786-5507

Other offices and agencies with responsibility for the following activities for pregnant and parenting teenagers:

Preventive/Contraceptive Information and Services: Bureau of Family Planning, Department of Health (BFP/DOH)

Sex Education: BFP, DOH

Family Life Education: BFP, DOH

Maternal Health and Medical Care: Maternal and Child Health (MCH), DOH

Perinatal Medical Care: MCH, DOH

Infant/Child Health and Medical Care: MCH, DOH

Educational and Vocational Assistance and/or Training: Virginia Employment Commission, Department of Education

PROGRAMS AND RESOURCES

1. School Age Parent Committee. The committee receives both Federal and State funding, and involves the Departments of Health, Mental Health, and Education, as well as Planned Parenthood and local schools. Emphasis is on professional and community education. The committee was formed in 1978.

2. Perinatal Council. Begun in 1980, the council is responsible for ongoing planning. The Department of Health has primary responsibility for the council, which receives Federal and State funding.

3. Norfolk Adolescent Pregnancy Prevention and Services Project (NAPPS).

Contact person: Margaret J. Kelly, Ph.D., Director
Norfolk State University
2401 Corprew Ave.
Norfolk, VA 23504
Phone number: (804) 623-8651

4. Park School.

Contact person: Jean Stephan, Head Teacher
100 W. Baker St.
Richmond, VA 23220
Phone number: (804) 780-4641

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

In 1984, the Departments of Health and Mental Health and Mental Retardation initiated "Better Beginnings for Virginia's Children." Coalitions of local community organizations, emphasizing family life education, are involved, and small grants are provided to projects which attempt to discourage teen pregnancy. A companion project, the Virginia Resource Mothers program, has received $100,000 from the Department of Health for pilot programs in three urban areas to provide counseling and support to pregnant adolescents.

State's response to survey submitted by:

Joseph L. Fisher, Secretary of Human Resources
Office of the Governor

DEMOGRAPHICS

Total female adolescent population by age

	1978	1979	1980	1981	1982	1983
10-14	152,051	154,411	156,835	160,878	159,380	156,420
15-19	177,848	183,883	179,691	174,385	168,735	162,201
15-17	N/A	107,607	104,933	101,193	96,577	93,153
18-19	N/A	76,276	74,758	73,192	72,158	69,048

Number of births to teenagers by age of mother

	1978	1979	1980	1981	1982	1983
10-14	63	87	106	83	93	86
15-19	7657	8177	8383	8195	7452	7066
15-17	N/A	2604	2608	2590	2275	2129
18-19	N/A	5573	5775	5605	5177	4937

Estimated number of births to teenagers

	1984	1985	1986	1987	1988	1989	1990
Under 20	6321	5984	5882	5932	6081	6205	6462

Number of abortions by age of mother

	1978	1979	1980	1981	1982	1983
10-14	241	197	201	202	189	211
15-19	8875	8462	8618	8153	7313	6913
15-17	N/A	3662	3650	3393	3032	2811
18-19	N/A	4800	4968	4760	4281	4102

Number of fetal deaths by age of mother

	1979	1980	1981	1982	1983
10-14	3	4	2	3	0
15-19	82	65	69	48	52
15-17	33	21	26	20	11
18-19	49	44	43	28	41

Number of not married female adolescent parents by age

	1983
10-14	75
15-19	3440

HEALTH INDICATORS

Infant mortality rate by age of mother

	1980
10-14	28.3
15-17	18.8
18-19	13.3

IMR for all births, 1983: 9.5

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	7.9%	16.7%	11.1%	11.1%
15-17	N/A	7.8	7.8	7.9
18-19	N/A	6.5	6.1	6.7

All low-birthweight births, 1983: 5.2%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978*	1980	1982	1983
Under 20	55.8%	58.3%	53.4%	52.6%

1983 rate for mothers, all ages: 77.6%
* For 1978 only, first trimester care for teens is by occurrence and births are for residence.

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Office of Maternal and Child Health Services, Perinatal Programs
Department of Social and Health Services, Division of Health
Airdustrial Park, Building 3, LC-11A
Tumwater, WA 98501

Contact person: Patricia Wilkins, Chief, Office of Maternal and Child Health Services
Phone number: (206) 753-7021

Other offices and agencies with responsibilitiy for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Family Planning/Schools

Preventive/Abstinence Education: Family Planning/Health Education in Schools

Sex Education: Family Planning Services Section

Family Life Education: Maternal and Child Health Services (MCHS)

Maternal Health and Medical Care: Medicaid; MCHS

Perinatal Medical Care: Medicaid; MCHS Perinatal Program

Infant/Child Health and Medical Care: Medicaid; MCHS

Educational and Vocational Assistance and/or Training: Supt. of Public Instruction, Employment Security

Life Skills Development Training: MCHS

Adoption Services: Dept. of Social and Health Services (DHSH), Children and Family Services

Child Care: Children and Family Services, DHSH

Evaluation: Research and Data Analysis; Individual Service Programs

New Programs and Policy Development: DGHS Management Team

PROGRAMS AND RESOURCES

1. Adolescent Pregnancy Demonstration Project. This federally funded program provides comprehensive service delivery including case management, counseling, transportation, follow-up and evaluation. It is administered by the Office of Maternal and Child Health, Dept. of Social and Health Services. Funding comes from the Title V, MCH block grant. Contracts have been awarded to Planned Parenthood of Yakima County, Chelan-Douglas County Health Department, Columbia Basin Alternative High School in Grant County, and Youth Help in Grays Harbor County. The project began in September 1983.

Contact person: Gloria Houp, R.N., M.N.
Public Nursing Consultant
Parent-Child Health Services
Mailstop LC-12A
Department of Social and Health Services
Olympia, WA 98504
Phone Number: (206) 754-0818

2. Adolescent Pregnancy Project. Started in 1981, this federally funded project provides the same services as the Adolescent Pregnancy Demonstration Project, but is administered by the Tacome-Pierce County Health Department, and receives its funding from the Adolescent Family Life Act.

Contact person: Arlene Brines
Phone number: (206) 593-4813

3. Home tutoring for pregnant and parenting students. This is a State-funded program run in the schools with individual students, and is administered by the Office of the Superintendent of Public Instruction (OSPI).

4. Inservice program for teachers of home and family life education, and parenting adolescents. This program operates in local school districts, and is run by OSPI.

5. Special Education Program for Teen Parents. This program receives Federal funds and is operated in local school districts by OSPI.

6. Child Care Services for Vocational Education Students. This program receives Federal funds and is operated in local school districts by OSPI.

7. Parenting Training Modules. This teacher's guide: "You and Your Baby: A parenting program for parents and babies from birth to six months," was produced by the Maternal and Child Health Program, DSHS. This guide provides teaching tips, suggestions for marketing the program, as well as a complete curriculum covering child development, and sources for curriculum materials.

Contact person: Melinda McMahan, Health Program Specialist
Parent-Child Health Services
Mailstop LC-12A
Department of Social and Health Services
Olympia, WA 98504
Phone Number: (206) 753-6153

8. TEEN POWER (Peer Outreach Workers With Education Resposibilities). This project is being developed by the Office of Maternal and Child Health, DSHS, and submitted an application to the Department of Health and Human Services in April 1985. The project will train adolescent parents to reach out to their peers in order to support them, provide role models, and teach life management skills. Health professionals and teenage mothers/outreach workers will be trained in three rural counties in the use of prenatal, postpartum and development assessment tools, relating sensitively and realistically with adolescent mothers and their families, how to make home visits, as well as other support systems. State Maternal and Child health staff will coordinate the program, and services will be provided under local health department clinic auspices.

Contact person: Fran Moellman, Manager
Parent-Child Health Services
Mailstop LC-12A
Department of Social and Health Services
Olympia, WA 98504
Phone number: (206) 753-2428

9. Educational alternatives for teenage parents. Many schools provide special programs for parenting teenagers. Washington State has a number of alternative high schools, community colleges and vocational-technical institutes which provide home and family life classes to older teenagers.

Contact person: Gail Cowan, Home and Family Life Instructor
A-I School
Clover Park School District
Tacoma, WA
Phone number: (206) 756-8495

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Policy changes have been made in: (1) involvement of fathers, with increased child support collection efforts; (2) child care, with the establishment of a new division of Children and Family Services; (3) infant health and medical care; (4) maternal health and medical care; and (5) delivery services. The State noted an increase, followed by reductions in some health related services.

State's response to survey submitted by:

The Honorable Booth Gardner
Governor
State of Washington

WEST VIRGINIA

DEMOGRAPHICS

Number of births to teenagers by age of mother

	1978	1980
10-14	96	80
15-19	6061	5824
15-17	2270	2130
18-19	3791	3694

Number of abortions to teenagers by age of mother

	May-December 1984
10-14	37
15-17	235

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1980	1982	1983
10-14	9.3%	8.5%	12.7%
15-19	8.5	7.8	8.4

All low-birthweight births, 1983: 6.7%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
Under 20	45.6%	47.7%	48.7%	49.4%

1983 rate for mothers, all ages: 72.0

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1978	1980	1982	1984
Under 20	226	230	200	200

Number of female adolescents dropping out of school due to pregnancy or child care responsibilities

	1978	1980	1982	1984
Under 20	226	230	200	200

EMPLOYMENT INDICATORS

Adolescent unemployment rate

	1980	1982	1984
16-19	27.1%	32.0%	29.4%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Commission on Children and Youth
Department of Human Services
1900 Washington Street East
Charlston, WV 25305

Contact person: Thomas Llewellyn, Executive Director
Phone number: (304) 348-0258

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Department of Health (DOH)

Maternal Health and Medical Care: DOH

Perinatal Medical Care: DOH

Infant/Child Health and Medical Care: DOH

Educational and Vocational Assistance and/or Training: Department of Education (DOE)

Life Skills Development Training: DOE

Adoption Services: Department of Human Services (DHS)

Child Care: DHS

PROGRAMS AND RESOURCES

1. Youth Health Service. This five-county, State-funded program provides comprehensive primary and secondary health services to adolescents and their relatives and friends. Services include counseling and health education, referral, parenting training, outreach, community education, and family planning. The program operates under the auspices of Family Health Service, Inc., and Memorial General Hospital.

Contact person: Fran Jackson, Director
Memorial General Hospital
Youth Health Services
1120 Harrison Avenue
P.O. Box 1759
Elkins, WV 26241
Phone Number: (304) 636-9450

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

West Virginia has a Statewide Task Force on Adolescent Parenting. The mandate of the Task Force is to develop recommendations for strengthening programs and services for pregnant and parenting teenagers. It is a joint effort by the Departments of Health, Education and Human Services. The study began in April 1984.

House Bill 1278, the Pre-abortion Notification of Parent or Guardian of Unemancipated Minor, went into effect in May 1984. It requires physicians to notify the parent or guardian prior to the performance of an abortion on an unemancipated minor.

State's response to survey submitted by:

The Honorable Arch A. Moore, Jr.
Governor
State of West Virginia

DEMOGRAPHICS

Total female adolescent population by age

	1980
10-14	40,469
15-19	230,876
15-17	133,921
18-19	96,955

Number of births to teenagers by age of mother

	1978	1980	1982
Under 18	2937	2834	2543
18-19	5940	6379	5659

Number of miscarriages by age of mother

	1980	1982
Under 18	27	26
18-19	60	48

Number of not married parenting adolescents by age

	1980	1982
10-14	91	89
15-19	4562	4461
15-17	1924	1844
18-19	2638	2617

HEALTH INDICATORS

Infant mortality rate by age of mother

	1980	1982
15-17	24.5	19.2
18-19	16.2	11.7

IMR for all births, 1983: 9.6

Percentage of births to teenagers which are low birthweight

	1980	1982
10-17	9.1%	N/A
10-14	N/A	16.5
15-17	N/A	9.1
18-19	7.5	7.3

All low-birthweight births, 1983: 5.4%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1982
Under 20	60.6%

1983 rate for mothers, all ages: 83.8%

EDUCATIONAL INDICATORS

Number of female adolescents dropping out of school

	1981-82	1982-83	1983-84
Under 20	18,589	14,299	14,227

Number of female adolescents dropping out of school due to pregnancy or child care responsibilities*

	1981-82	1982-83	1983-84
Under 20	379	314	294

* Does not include an unknown portion of females who were listed as "excused."

ECONOMIC INDICATORS

Number of female AFDC recipients by age*

	April 1984
14-19	18,536
14	3396
15	3165
16	3062
17	2878
18	2776
19	3259

* These recipients include "Caretaker" adolescents, both pregnant and not pregnant, "Dependent" adolescents, both pregnant and not pregnant, and "AFDC Maternity" adolescents. Only some portion of "Dependent, Not Pregnant Adolescents" would be pregnant or parenting.

Adolescent unemployment rate

	1978	1980	1982	1984
Under 20	12.8%	17.4%	21.6%	18.4%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Health issues: Maternal and Child Health Unit
Bureau of Community Health and Prevention
Department of Health and Social Services
Room 121, 1 W. Wilson St.
Madison, WI 53702

Contact person: Lynn Reineking, Adolescent Health Specialist
Phone Number: (608) 266-6988

Social Service Issues: Office for Children, Youth and Families
Bureau of Human Resources
Department of Health and Social Services
Room 470, 1 W. Wilson St.
Madison, WI 53702

Contact Person: Barbara Bernard, Teen Pregnancy Planner
Phone Number: (608) 267-2079

Education Issues: Bureau for Pupil Services
Division of Handicapped Children and Pupil Services
Department of Public Instruction
4th Floor, 125 S. Webster
P.O. Box 7841
Madison, WI 53707

Contact Person: Lorraine Davis, Supervisor,
School Age Mothers Programs
Phone Number: (608) 266-7921

Other offices and agencies with responsibility for the following activities for pregnant and parenting adolescents:

Preventive/Contraceptive Information and Services: Maternal and Child Health Unit, Division of Health, Department of Health and Social Services (MCH Unit/DOH/DHSS)

Sex Education: Department of Public Instruction (DPI)

Family Life Education: DPI

Maternal Health and Medical Care: MCH Unit/DOH/DHSS

Perinatal Medical Care: MCH Unit/DOH/DHSS

Infant/Child Health and Medical Care: MCH Unit/DOH/DHSS

Adoption Services: DHSS (Special needs adoptions only; counties are responsible for other adoption services.)

Child Care: DHSS/Division of Community Services

PROGRAMS AND RESOURCES

1. Adolescent Pregnancy Prevention. A federally funded program, administered by the Department of Health and Social Services, Division of Community Services. Begun January 1, 1985.

2. Economic Self-Sufficiency for Adolescents in AFDC Households. A federally funded program administered by DHSS, Division of Community Services. Begun January 1, 1985.

3. Teen Pregnancy Service. In its fifth year of operation, the project, located at Family Hospital, offers comprehensive primary care services to pregnant adolescents between ages 14 to 18 and their infants (through age 3), residing in Milwaukee County. The program admits about 250 new pregnant teenagers, and roughly 200 new infants per year. It is also a certified WIC and EPSDT site and receives MCH block grant funding.

Contact person: Mary Jo Baisch, Director
Family Hospital Teen Pregnancy Service
2711 West Wells
Milwaukee, WI 53208
Phone number: (414) 937-2768

4. Teen Health Service. This project, begun in 1983, provides prenatal care with follow-up and well-baby care using Certified Nurse Midwives and Pediatric Nurse Practitioners, as well as supportive services such as nutrition counseling and referrals. The program operates out of Lutheran Hospital, and is run in collaboration with Gunderson Clinic in LaCrosse. It receives MCH block grant funding, and serves roughly 150 pregnant adolescents, and 125 infants annually.

Contact person: Tim Skinner, Project Administrator
LaCrosse Lutheran Hospital: Teen Health Service
1910 South Ave.
LaCrosse, WI 54601
Phone number: (608) 785-0530

5. Project Model Health. This school-based project aims to change adolescent behavior in five areas; nutrition, drinking and driving, sexuality, marijuana use, and tobacco use. The goal regarding sexual behavior is to delay sexual intercourse as long as possible. The program is being piloted in a junior high school targetting 160 students, and is federally funded through MCH-SPRANS.

Contact person: Baxter Richardson, Director
Project Model Health
Bureau of Community Health and Prevention
Wisconsin Division of Health
P.O. Box 309, 1 W. Wilson St.
Madison, WI 53701
Phone number: (608) 267-77321

6. Infant Child Learning Laboratory. The Kenosha Unified School District has established this laboratory as a means of providing infant care for the children of school-age parents, as well as providing parenting and child development education to students.

Contact Person: Director
Kenosha Unified School District
913 57th St.
Kenosha, WI 53140
Phone number: (414) 656-6160

7. Connect Project. Operated by a community-based organization serving families, the Connect Project matches teen parents with adult volunteers who help the teens in parenting roles.

Contact person: Peg Scholtes
Family Enhancement Center
605 Spruce St.
Madison, WI 53715
Phone number: (608) 256-3890

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

The "Healthy Birth Program" is in its first year. A three-year program, the goal is to "improve the outcome of pregnancy and an infant's first year of life. While the program is intended to serve the entire MCH population, special efforts will be made to reach high risk populations such as adolescents and low income families." Under the initiative, adolescents are the target population in projects aimed at early identification of pregnancy and referral for prenatal care.

Several policy changes were reported. In Wisconsin programs for school-age mothers are no longer categorized as part of Special Education for reporting purposes, although they still receive the same State funding match as special education programs. Wisconsin reported that the State is no longer involved in healthy-infant adoptions, now only handling "special needs" adoptions. Local and voluntary agencies handle healthy-infant adoptions. With regard to child care, Wisconsin noted that:

> Counties must handle eligible child care applications on a first-come, first serve basis, except when the service is intended to prevent or remedy child abuse and neglect. There may be no other priority basis, such as enabling teen parents to return to school or work.

State's response to survey submitted by:

Tom Kaplan, Director, Bureau of Planning
Department of Health and Social Services

WYOMING

DEMOGRAPHICS

Total female adolescent population by age

	1980	1983
10-14	18,005	18,635
15-19	20,560	20,520
15-17	11,775	N/A
18-19	8,785	N/A

Number of births to teenagers by age of mother

	1978	1980	1983
10-14	8	15	14
15-19	1349	1618	1261
15-17	N/A	522	366
18-19	N/A	1096	895

HEALTH INDICATORS

Percentage of births to teenagers which are low birthweight

	1978	1980	1982	1983
10-14	25.0%	13.3%	13.3%	28.6%
15-19	10.3	N/A	N/A	N/A
15-17	N/A	9.8	8.6	8.5
18-19	N/A	8.3	8.3	5.9

All low-birthweight births, 1983: 7.1%

Percentage of live births to adolescent women who received prenatal care in the first trimester

	1978	1980	1982	1983
15-19	60.0%	59.6%	61.9%	59.5%

1983 rate for mothers, all ages: 78.7%

AGENCIES AND DEPARTMENTS

Lead agency responsible for coordinating programs, policies, and projects for pregnant and parenting teenagers

Family Health Service
Division of Health and Medical Services
4th floor, Hathaway Building
Cheyenne, WY 82002

Contact person: R. Larry Meuli, M.D., Director, Maternal and Children's Health Services
Phone number: (307) 777-6297

Other offices and agencies with responsibility for the following activities:

Adoption Services: Department of Public Assistance and Social Services (DPASS)

Child Care: DPASS

STATEWIDE INITIATIVES AND RECENT POLICY CHANGES

Changes in infant health and medical care and maternal health and medical care were indicated. No description of the changes were provided, however.

State's response to survey submitted by:

Lawrence J. Cohn, M.D., Administrator
Department of Health and Social Services

APPENDIX I

SURVEY OF STATES ON ADOLESCENT PREGNANCY AND PARENTHOOD

ADOLESCENT PREGNANCY SURVEY

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DEMOGRAPHIC DATA AND PROJECTIONS

1. We currently have estimates by State on numbers of adolescent females between 10 and 19 years of age, as well as estimated numbers of adolescent births, abortions, and miscarriages. (See Appendix B.)

Please complete the chart below including any more recent data you may have, any data that differ from the information provided in Appendix B, and any data on other age groupings listed in the chart.

		1978			1980			198__		
		10-14	15-19		10-14	15-19		10-14	15-19	
			15-17	18-19		15-17	18-19		15-17	18-19
Males	Total									
Females	Total									
	Births									
	Abortions									
	Miscarriages									
Total Number of Parenting Adolescents*										
Married Parenting Adolescents										
Not Married Parenting Adolescents										

* Parenting adolescents include all persons under the age of 20 who have given birth to a child during their adolescent years and maintain primary responsibility for the care of the child.

2. Has your State or any other public or private organization in your State projected for the next ten years or any future period of time the number of births to adolescents or the rates of teenage pregnancy? If so, please complete the following chart.

	Estimated Numbers		
	19___	19___	19___
Teenage Pregnancy Rate			
Births			

3. Do you, or any organization in your State, estimate the number of sexually active and non-sexually active adolescents in your State? If so, please describe the method by which these estimates are made.

STATE ACTIVITIES

4. What agency or office in your State has lead responsibility for coordinating programs, policies, and projects in your State for pregnant and parenting adolescents and other teenagers? Please provide the information requested below.

Agency/Office: ______________________________

Department: ______________________________

Contact Person: ______________________________

Title: ______________________________

Address: ______________________________

____

Telephone Number: ______________________________

Reports to: ______________________________

5. Please indicate the agency or office in your State, if any, that has lead responsibility for the following activities:

1) Services*:

a) Preventive/Contraceptive Information and Services:
Pregnant and parenting adolescents: ____________________
All other adolescents: ____________________

b) Preventive/Abstinence Education:
All adolescents: ____________________

c) Sex Education:
Pregnant and parenting adolescents: ____________________
All other adolescents: ____________________

d) Family Life Education:
Pregnant and parenting adolescents: ____________________
All other adolescents: ____________________

e) Maternal Health and Medical Care:
Pregnant and parenting adolescents: ____________________

f) Perinatal Medical Care:
Pregnant and parenting adolescents: ____________________

g) Infant/Child Health and Medical Care:
Parenting adolescents: ____________________

h) Educational and Vocational Assistance and/or Training:
Pregnant and parenting adolescents: ____________________

i) Life Skills Development Training:
Pregnant and parenting adolescents: ____________________
All other adolescents: ____________________

j) Adoption Services:
Pregnant and parenting adolescents: ____________________

k) Child Care:
Parenting adolescents: ____________________

2) Evaluation ____________________

3) New Programs and Policy Development ____________________

---

* See Service Definitions (Appendix A)

6. Please complete the following chart on special state initiatives to coordinate, research, plan for or otherwise provide for services specifically designed to prevent adolescent pregnancy and/or to ameliorate the effects of adolescent pregnancy and/or parenthood. Please describe on an attached sheet any major accomplishments of the initiatives to date, including the numbers of adolescents served.

Initiative Name and Description	Agencies Involved in the Implementation	Type of Organization or Program at which Initiative is Directed (e.g. clinics, school-based programs, community health centers, etc.)	Status of Initiative	Date Begun	Mandate for Initiative			Amount and Source of Funding		
					executive order	legislative	other	federal	state	private

SERVICES AND PROGRAMS FOR TARGET POPULATION

7. If your state has information concerning the following services for adolescents, please provide that information in the chart below for the years indicated and any more recent year for which you have data.

If you have data for these or any other years, but not in the form presented below, please attach this material. If data are available only for those programs receiving resources from the state, please indicate.

	Number of Service Projects				Funding Levels							
					Federal				State			
	1978	1980	1982	198	1978	1980	1982	198	1978	1980	1982	198
Preventive/ Contraceptive Services												
Preventive/ Abstinence Education												
Sex Education												
Family Life Education												
Maternal Health Care Services												
Perinatal Medical Care Services												
Infant/Child Health Care Services												
Employment and Training Assistance												
Life Skills Development Training												
Adoption Services												
Child Care for Adolescent Parents												

Do you collect data on the number of locally funded programs and their funding levels?

_____ Yes (If so, please attach this information.)
_____ No

Do you collect data on the number of privately funded programs and their funding levels?

_____ Yes (If so, please attach this information.)
_____ No

8. If your State has any data on any of the following program indices please provide these data below. Also, if you are aware of any public or private organization which collects this information, please include the data, if available, or the name and address of the organization if the data are not available.

	1978	1980	1982	(Any more recent year for which data are available) 198__
HEALTH:				
Rate of repeat pregnancies to adolescents during their teen years	_____	_____	_____	_____
Rate of repeat abortions among adolescents	_____	_____	_____	_____
Number and percent of pregnant adolescents receiving prenatal care within the first trimester of their pregnancy	_____ ____%	_____ ____%	_____ ____%	_____ ____%
Infant mortality rates for infants born to adolescent mothers age 10 to 14	_____	_____	_____	_____
Infant mortality rates for infants born to adolescent mothers age 15 to 17	_____	_____	_____	_____
Infant mortality rates for infants born to adolescent mothers age 18 to 19	_____	_____	_____	_____
Number and percent of adolescent mothers age 10 to 14 bearing low birth weight infants	_____ ____%	_____ ____%	_____ ____%	_____ ____%
Number and percent of adolescent mothers age 15 to 17 bearing low birth weight infants	_____ ____%	_____ ____%	_____ ____%	_____ ____%
Number and percent of adolescent mothers age 18 to 19 bearing low birth weight infants	_____ ____%	_____ ____%	_____ ____%	_____ ____%

8. Continued

	1978	1980	1982	198_ (Any more recent year for which data are available)
EDUCATIONAL AND VOCATIONAL TRAINING:				
Number and percent of pregnant and parenting adolescents finishing high school with their class or within one year of their intended graduation date	_____ ___%	_____ ___%	_____ ___%	_____ ___%
Number and percent of pregnant and parenting adolescents completing the General Equivalency Degree (G.E.D.) within two years of their intended graduation date	_____ ___%	_____ ___%	_____ ___%	_____ ___%
Number of female adolescents dropping out of school	_____	_____	_____	_____
Number of female adolescents dropping out of school who give pregnancy or child care responsibilities as the primary reason for leaving school	_____	_____	_____	_____
Number and percent of pregnant and parenting adolescents completing vocational education programs within two years of their intended graduation date	_____ ___%	_____ ___%	_____ ___%	_____ ___%
EMPLOYMENT AND ECONOMIC SUPPORT:				
Number and percent of pregnant and parenting adolescents obtaining employment	_____ ___%	_____ ___%	_____ ___%	_____ ___%
Number of pregnant and parenting adolescents assisted by Aid to Families with Dependent Children	_____	_____	_____	_____
Unemployment rate among adolescents in your state	_____	_____	_____	_____
Unemployment rate among adolescent mothers	_____	_____	_____	_____
Unemployment rate among adolescent fathers	_____	_____	_____	_____
Percent of adolescent fathers providing child support to their infants	___%	___%	___%	___%

8. Continued

				(Any more recent year for which data are available)
	1978	1980	1982	198__
ADOPTION AND FOSTER CARE				
Number of adoptions by unrelated persons of infants born to adolescents	____	____	____	____
Number and percent of black adolescents choosing adoption	____ ____%	____ ____%	____ ____%	____ ____%
Number and percent of white adolescents choosing adoption	____ ____%	____ ____%	____ ____%	____ ____%
Number and percent of other adolescents choosing adoption	____ ____%	____ ____%	____ ____%	____ ____%
Number of infants born to adolescent parents and placed in foster care	____	____	____	____
Percent of black infants born to adolescents and placed in foster care	____%	____%	____%	____%
Percent of white infants born to adolescents and placed in foster care	____%	____%	____%	____%
Percent of other infants born to adolescents and placed in foster care	____%	____%	____%	____%
OTHER:				
Other indices used by your State (please specify) ____________	____	____	____	____
____________	____	____	____	____
____________	____	____	____	____

9. Please provide the numbers served and the percent of pregnant, parenting and all other adolescents served by programs in the following locations in 1978, 1980, and 1982.

		Pregnant		Adolescent Parents				Other Teenagers			
		Females		Females		Males		Females		Males	
		#	%	#	%	#	%	#	%	#	%
School-based Programs	1978										
	1980										
	1982										
Community Health Centers	1978										
	1980										
	1982										
Hospitals	1978										
	1980										
	1982										
Private Clinics and Physicians	1978										
	1980										
	1982										
Social Service Agencies	1978										
	1980										
	1982										
Other Community Organizations	1978										
	1980										
	1982										
Foster Homes	1978										
	1980										
	1982										
Maternity Homes	1978										
	1980										
	1982										

10. These are examples of Federal programs with expenditures for services to adolescent parents and their children and to adolescents at risk of becoming pregnant. Please complete the chart below on the funding levels and the number of adolescents served for each of the following programs. If data exist only for programs receiving assistance from the State, please indicate.

Source of Funding	Amount of Funding			Total Funding Specifically Directed to Services for Adolescents			Number of Adolescents Served			Funding Specifically Directed to Services For Pregnant and Parenting Adolescents			Number of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
FEDERAL: TITLE V Maternal and Child Health															
TITLE X Family Planning															
TITLE XIX Medicaid															
TITLE XX Social Services															
Adolescent Family Life Act*															
Education Consolidation and Improvement Act of 1981** (Chapters 1&2)															
WIC Women, Infants and Children Supplemental Feeding Assistance Program															

* In 1981, the Adolescent Family Life program replaced the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978.

** In 1981, ECIA replaced the Elementary and Secondary Education Act.

10. Continued

Source of Funding	Amount of Funding			Total Funding Specifically Directed to Services For Adolescents			Number of Adolescents Served			Funding Specifically Directed to Services for Pregnant and Parenting Adolescents			Number of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
Aid to Families with Dependent Children															
JTPA* Job Training and Partnership Act															
TITLE IV-E Adoption Assistance															
Food Stamp Program															
Low Income Public Housing															
Leased Housing Assistance															
OTHER FEDERAL PROGRAMS (list)															

* JTPA replaced the Comprehensive Employment and Training Act (CETA) in 1983.
Please provide the appropriate data from both the JTPA and CETA.

11. Please specify state and private resources allocated for activities specifically designed to prevent adolescent pregnancy and assist pregnant and parenting adolescents.

Source of Funding	Amount of Funding			Total Funding Specifically Directed to Services For Adolescents			Number of Adolescents Served			Funding Specifically Directed to Services For Pregnant and Parenting Adolescents			Number of Pregnant and Parenting Adolescents Served		
	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982	1978	1980	1982
STATE: (list) 1)															
2)															
3)															
PRIVATE* : (list) 1)															
2)															
3)															

* Private sources may include, among others, churches, foundations, corporations, etc.

POLICY ISSUES

12. Please specify any policy or legislative recommendations to improve the delivery of prevention or assistance services to pregnant and parenting adolescents and other teenagers. Are there specific problems or strengths in any of the programs or policies listed below? Please specify other federal, state, and local programs for which you have recommendations.

PROGRAMS	SPECIFIC POLICIES AND THEIR EFFECT
FEDERAL PROGRAMS: TITLE V Maternal and Child Health	
TITLE X Family Planning	
TITLE XIX Medicaid	
TITLE XX Social Services	
Adolescent Family Life	
WIC Women, Infants and Children Supplemental Feeding Program	
Aid to Families with Dependent Children	
TITLE IV-E Adoption Assistance	
OTHER FEDERAL PROGRAMS: (please specify)	
STATE PROGRAMS: (please specify)	
LOCAL PROGRAMS: (please specify)	

13. Have recent changes in Aid to Families with Dependent Children (AFDC) and Child Health Assurance Program (CHAP) incorporated in the Deficit Reduction Act of 1984, affected your ability to provide services to pregnant and parenting adolescents? If so, please describe.

14. Within the last five years, have there been any policy changes in your State with respect to the following areas as they relate to adolescent pregnancy and parenthood? If so, please attach information on the relevant statutory, regulatory, or administrative changes.

YES	NO	
___	___	Vocational Education
___	___	Standard Education
___	___	Provision of Contraceptive Services
___	___	Provision of Contraceptive Information
___	___	Sex Education
___	___	Parental Notification/Consent
___	___	Parental Involvement
___	___	Involvement of Father
___	___	Adoption Services
___	___	Adoption Counseling
___	___	Involvement of Fathers in Adoption Proceedings
___	___	Foster Care Services
___	___	Abortion Counseling
___	___	Abortion Services
___	___	Housing
___	___	Child Care
___	___	Infant Health and Medical Care
___	___	Maternal Health and Medical Care
___	___	Delivery Services

EVALUATION ISSUES

15. Please provide us with information on any model programs, public or private, in your State, specifically designed to prevent adolescent pregnancy or to assist pregnant and parenting adolescents.

We are particularly interested in the elements which contributed to the success of the project, the criteria used to measure the success of the project, and the factors which facilitated the creation and administration of this project. Please include the name, address, and telephone number of a person at each project who may be contacted by people in other states.

16. What have you learned does not work? If you have specific examples of programs or project components that have not worked, please provide us with this information.

17. Do you see the existing prevention and assistance services in your State as adequate to meet the needs of adolescents in your state? Please comment.

APPENDICES

APPENDIX A

SERVICES FOR ADOLESCENTS*

PREVENTIVE/CONTRACEPTIVE INFORMATION AND SERVICES
Contraceptive information, counseling, examinations, and services

PREVENTIVE/ABSTINENCE EDUCATION
Education devoted to encouraging the postponement of adolescent premarital sexual activity

SEX EDUCATION
Information on human reproduction and birth control

FAMILY LIFE EDUCATION
Comprehensive education on the family unit, the functioning of the family unit, values clarification, child development

MATERNAL HEALTH AND MEDICAL CARE
Pregnancy testing, prenatal and postnatal medical care, maternity counseling, nutritional counseling, childbirth education, postpartum home health care, and health education (nutrition, family health, first aid), dental care, venereal disease testing, counseling, and treatment

PERINATAL MEDICAL CARE
Delivery services and newborn medical care

INFANT/CHILD HEALTH AND MEDICAL CARE
Pediatric care

EDUCATIONAL AND VOCATIONAL ASSISTANCE AND TRAINING
Educational and vocational counseling and/or referral, G.E.D. preparation, job readiness training, skill training, work experience, special education classes, tutoring

LIFE SKILLS DEVELOPMENT TRAINING
Consumer/homemaking education, nutritional education/counseling, housing information, financial planning

ADOPTION SERVICES
Adoption services and counseling

CHILD CARE FOR ADOLESCENT PARENTS
Infant, toddler, preschool, and school-aged child care

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* The terms adolescent and teenager, for the purposes of this survey, will be used interchangably to refer to any person between the ages of 10 and 19.

APPENDIX B 1/

ESTIMATED NUMBER OF BIRTHS, ABORTIONS, AND MISCARRIAGES
FOR ADOLESCENT FEMALES AGE 10 TO 14
FOR 1978

1978	births to adolescents	abortions to adolescents	miscarriages to adolescents
U.S. TOTAL	10,770	15,110	3,670
ALABAMA	410	260	110
ALASKA	10	20	10
ARIZONA	90	120	30
ARKANSAS	220	80	50
CALIFORNIA	780	2,200	380
COLORADO	80	160	30
CONNECTICUT	90	140	30
DELAWARE	40	80	20
DISTRICT OF COLUMBIA	70	180	30
FLORIDA	650	940	220
GEORGIA	580	550	170
HAWAII	20	30	10
IDAHO	20	20	10
ILLINOIS	590	700	190
INDIANA	250	190	70
IOWA	60	90	20
KANSAS	70	100	30
KENTUCKY	260	270	80
LOUISIANA	410	200	100
MAINE	20	30	10
MARYLAND	240	710	120
MASSACHUSETTS	90	210	40
MICHIGAN	350	450	110
MINNESOTA	60	90	20
MISSISSIPPI	420	150	100
MISSOURI	220	270	70
MONTANA	10	30	10
NEBRASKA	30	50	10
NEVADA	30	70	10
NEW HAMPSHIRE	10	40	10
NEW JERSEY	280	550	110
NEW MEXICO	60	50	20
NEW YORK	520	1,390	240
NORTH CAROLINA	370	530	130
NORTH DAKOTA	10	20	—
OHIO	380	340	110
OKLAHOMA	140	150	40
OREGON	70	110	30
PENNSYLVANIA	380	690	150
RHODE ISLAND	20	20	10
SOUTH CAROLINA	360	260	100
SOUTH DAKOTA	20	10	10
TENNESSEE	360	260	100
TEXAS	1,070	1,210	340
UTAH	40	10	10
VERMONT	10	10	--
VIRGINIA	280	470	100
WASHINGTON	60	320	40
WEST VIRGINIA	100	90	30
WISCONSIN	70	150	30
WYOMING	10	30	—

1/ Statistics in Appendix B compiled by the Alan Guttmacher Institute

-- Less than 5

ESTIMATED NUMBER OF BIRTHS, ABORTIONS, AND MISCARRIAGES FOR ADOLESCENT FEMALES AGE 10 TO 14 FOR 1980

1980	births to adolescents	abortions to adolescents	miscarriages to adolescents
U.S. TOTAL	10,170	15,120	3,550
ALABAMA	360	280*	100*
ALASKA	10	20*	--*
ARIZONA	130	100	40
ARKANSAS	180	80	40
CALIFORNIA	770	2,420	400
COLORADO	60	150	30
CONNECTICUT	70	140	30
DELAWARE	30	50*	10*
DISTRICT OF COLUMBIA	80	220	40
FLORIDA	630	1,010*	230*
GEORGIA	580	500	160
HAWAII	20	50	10
IDAHO	30	20	10
ILLINOIS	610	420	160
INDIANA	220	250	70
IOWA	50	80*	20*
KANSAS	60	100	20
KENTUCKY	220	150*	60*
LOUISIANA	360	210	90
MAINE	20	40	10
MARYLAND	210	560	100
MASSACHUSETTS	70	260	40
MICHIGAN	330	820	150
MINNESOTA	40	120	20
MISSISSIPPI	380	130	90
MISSOURI	220	290	70
MONTANA	10	20	10
NEBRASKA	30	40	10
NEVADA	40	60	10
NEW HAMPSHIRE	10	40*	10*
NEW JERSEY	290	600	120
NEW MEXICO	70	50	20
NEW YORK	510	1,580	260
NORTH CAROLINA	370	470	120
NORTH DAKOTA	10	10	--
OHIO	350	370	110
OKLAHOMA	150	110	40
OREGON	70	160	30
PENNSYLVANIA	330	680	130
RHODE ISLAND	20	20	10
SOUTH CAROLINA	300	180	80
SOUTH DAKOTA	10	20	--
TENNESSEE	290	300	90
TEXAS	1,000	940*	290*
UTAH	40	40	10
VERMONT	10	20	--
VIRGINIA	230	450	90
WASHINGTON	110	240	50
WEST VIRGINIA	80	70*	20*
WISCONSIN	90	130*	30*
WYOMING	20	40	10

* Based on proportions in similar States.

-- Less than 5

ESTIMATED NUMBER OF BIRTHS, ABORTIONS, AND MISCARRIAGES FOR ADOLESCENT FEMALES AGE 15 TO 19 FOR 1978

1978	total number of adolescent females	births to adolescents	abortions to adolescents	miscarriages to adolescents
U.S. TOTAL	10,357,900	543,410	418,800	150,560
ALABAMA	180,600	13,040	5,350	3,140
ALASKA	20,500	1,080	700	290
ARIZONA	120,200	7,520	4,200	1,920
ARKANSAS	103,200	7,730	2,350	1,780
CALIFORNIA	998,500	53,110	72,620	17,890
COLORADO	137,800	6,160	5,720	1,800
CONNECTICUT	143,700	4,420	6,050	1,490
DELAWARE	30,900	1,470	1,510	450
DISTRICT OF COLUMBIA	30,900	1,980	3,280	720
FLORIDA	396,200	21,930	17,560	6,140
GEORGIA	245,800	17,550	9,720	4,480
HAWAII	39,600	2,160	1,420	580
IDAHO	44,300	2,770	690	620
ILLINOIS	537,800	28,070	19,490	7,560
INDIANA	256,900	15,220	6,280	3,670
IOWA	138,400	5,860	2,980	1,470
KANSAS	108,900	5,780	3,220	1,480
KENTUCKY	167,300	12,300	5,500	3,010
LOUISIANA	199,000	15,900	3,660	3,550
MAINE	53,100	2,500	1,470	650
MARYLAND	209,500	8,620	14,170	3,140
MASSACHUSETTS	279,800	7,740	12,070	2,750
MICHIGAN	470,600	21,560	14,930	5,800
MINNESOTA	200,100	6,830	5,540	1,920
MISSISSIPPI	121,000	10,520	2,580	2,360
MISSOURI	231,500	12,741	5,870	3,140
MONTANA	40,400	1,920	1,110	500
NEBRASKA	75,000	3,080	2,080	820
NEVADA	30,200	1,840	1,900	560
NEW HAMPSHIRE	39,400	1,500	1,430	440
NEW JERSEY	341,600	11,840	15,720	3,940
NEW MEXICO	65,230	4,610	1,890	1,110
NEW YORK	807,100	28,460	41,230	9,810
NORTH CAROLINA	263,300	16,980	10,380	4,430
NORTH DAKOTA	34,800	1,270	540	310
OHIO	527,100	26,440	15,340	6,820
OKLAHOMA	128,300	9,450	3,150	2,210
OREGON	110,000	5,590	4,560	1,570
PENNSYLVANIA	548,600	22,020	19,480	6,350
RHODE ISLAND	42,300	1,400	1,170	410
SOUTH CAROLINA	144,100	10,140	5,600	2,590
SOUTH DAKOTA	35,900	1,830	810	450
TENNESSEE	198,700	13,870	6,530	3,430
TEXAS	619,300	45,350	25,170	11,590
UTAH	66,800	4,370	700	950
VERMONT	23,900	880	850	260
VIRGINIA	247,700	11,970	11,900	3,590
WASHINGTON	170,600	7,660	10,680	2,600
WEST VIRGINIA	82,700	6,100	1,770	1,400
WISCONSIN	229,900	8,820	5,110	2,280
WYOMING	19,700	1,420	770	360

ESTIMATED NUMBER OF BIRTHS, ABORTIONS, AND MISCARRIAGES TO ADOLESCENT FEMALES AGE 15-19 FOR 1980

1980	total number of adolescent females	births to adolescents	abortions to adolescents	miscarriages to adolescents
U.S. TOTAL	10,410,100	552,160	444,780	134,910
ALABAMA	186,400	12,740	6,000*	3,150
ALASKA	17,300	1,120	740*	300
ARIZONA	123,800	8,100	5,020	2,120
ARKANSAS	105,700	7,880	2,670	1,840
CALIFORNIA	1,038,900	55,360	72,030	18,280
COLORADO	131,000	6,540	6,410	1,950
CONNECTICUT	142,100	4,340	5,700	1,440
DELAWARE	30,200	1,540	1,210*	430
DISTRICT OF COLUMBIA	29,600	1,850	3,380	710
FLORIDA	399,700	23,410	22,160*	8,900
GEORGIA	258,000	18,560	10,460	4,760
HAWAII	40,800	2,070	1,660	580
IDAHO	44,000	2,620	1,000	620
ILLINOIS	522,800	29,190	16,000	7,440
INDIANA	263,000	15,110	7,870	3,810
IOWA	137,400	5,900	3,430*	1,530
KANSAS	106,200	6,030	3,170	1,520
KENTUCKY	170,500	12,340	3,710*	2,840
LOUISIANA	212,300	16,140	5,190	3,750
MAINE	52,700	2,500	1,440	640
MARYLAND	199,700	8,670	12,790	3,010
MASSACHUSETTS	273,400	7,690	12,920	2,830
MICHIGAN	445,400	20,070	19,630	5,980
MINNESOTA	197,700	7,000	6,200	2,020
MISSISSIPPI	127,900	10,700	2,850	2,430
MISSOURI	226,500	13,090	7,620	3,380
MONTANA	36,000	1,750	1,150	460
NEBRASKA	72,900	3,280	1,760	830
NEVADA	34,300	2,010	2,300	630
NEW HAMPSHIRE	43,600	1,460	1,600*	450
NEW JERSEY	329,500	11,610	16,050	3,930
NEW MEXICO	65,200	4,690	2,340	1,170
NEW YORK	794,900	27,700	42,600	9,800
NORTH CAROLINA	274,800	15,820	10,330	4,200
NORTH DAKOTA	31,000	1,290	700	330
OHIO	499,500	26,210	17,410	6,980
OKLAHOMA	134,900	10,060	3,680	2,380
OREGON	111,100	5,660	5,820	1,710
PENNSYLVANIA	535,500	21,700	20,300	6,370
RHODE ISLAND	45,000	1,480	1,780	480
SOUTH CAROLINA	153,800	9,990	5,040	2,500
SOUTH DAKOTA	34,000	1,790	720	430
TENNESSEE	210,700	13,500	6,920	3,390
TEXAS	661,200	49,130	28,790*	12,700
UTAH	69,900	4,560	1,040	1,020
VERMONT	25,700	1,020	1,110	310
VIRGINIA	246,700	11,910	11,070	3,490
WASHINGTON	179,600	8,390	10,830	2,760
WEST VIRGINIA	86,000	5,830	1,740*	1,340
WISCONSIN	230,900	9,130	7,850*	2,610
WYOMING	20,600	1,620	600	380

* Based on proportions in similar States.

APPENDIX II

RATE OF RESPONSE TO SELECTED SURVEY QUESTIONS

The Committee's survey asked 26 questions concerning demographics, health, education and employment indicators, and adoption and foster care. Five of these questions were not answered by any States. Only six were answered by at least half the States.

None of the States provided information for the following questions on the survey: the number and percent of pregnant and parenting adolescents completing the General Equivalency Degree (G.E.D.) within two years of their intended graduation date; the number and percent of of pregnant and parenting adolescents completing vocational education programs within two years of their intended graduation date; the number and percent of pregnant and parenting adolescents obtaining employment; the unemployment rate among adolescernt mothers and fathers; and the percent of adolescent fathers providing child support to their infants.

Information provided varied widely from State to State. Some States were able to provide numbers for one year, others for four or more years. Some States could only report information for teenagers under age 20. Others could break the numbers down for 10 to 14 year olds, 15 to 17 year olds, and 18 to 19 year olds. Some States fell inbetween the two.

Female Population, Births, Pregnancy Projections, Abortions and Miscarriages

Thirty-two States reported the total number of female adolescents residing in the State. Nearly all the States (47) reported the number of births to teenagers, with one State reporting the teenage fertility rate instead. Seventeen States included numbers for the rate of repeat pregnancies. None of the States reported estimated pregnancy rates for future years, but four States gave estimated numbers of births to teenagers.

Thirty-five States reported the number of teenagers having abortions. One State reported the abortion rate for white teenagers only. Nineteen States gave figures for the rate of repeat abortions, and 25 States reported the number of miscarriages or fetal deaths by age of mother.

Low Birthweight, Prenatal Care, and Infant Mortality

More States reported low-birthweight rates than other health indicators. Forty States were able to report the percentage of births to teenagers which were low birthweight, while 27 States reported the percentage of live births to adolescent women who received prenatal care in the first trimester, and 26 States reported the infant mortality rate by age of mother.

Parenting Adolescents, Adoptions and Foster Care

The survey asked for the total number of parenting adolescents, as well as the number of married and not married parenting teens. Only one State was able to report the total number, although two other States reported the total number of female parenting adolescents. More States reported the number of not-married teen parents (7) than married teen parents (5), with seven additional States only reporting the numbers for females. Four States only reported the number or percent of births to unmarried teenagers.

Only three States were able to provide information about adoptions of children of teen parents, and only one State reported the percentage of infants born to teenagers who were placed in foster care.

Unemployment, AFDC, and School Completion

Sixteen States were able to report the adolescent unemployment rate, and 12 reported the number of teen parents receiving AFDC. Ten States reported the number of female adolecents dropping out of school, but only six States reported the number of female adolescents who dropped out of school due to pregnancy or child care responsibilities. The survey asked for the number and percent of pregnant and parenting adolescents finishing high school with their class or within one year of their intended graduation date. Only one State answered this question, but reported the number of single heads of households with dependents under age 22 who finished high school.

APPENDIX III

REFERENCES INCLUDING ALL DOCUMENTS SUBMITTED BY STATES

1. Alabama Survey.

2. Alaska--No Survey Document Submitted.
2.(a) Cover letter outlining activities of the Alaska State Legislature on adolescent pregnancy, from John R. Pugh, State Commissioner of Health and Social Services, March, 1985.
2.(b) Alaska Vital Statistics Annual Report (1981), selected statistics. Division of Administrative Services, Bureau of Vital Records, Department of Health and Social Services.
2.(c) Alaska Vital Statistics Annual Report, 1980.
2.(d) Alaska Vital Statistics Annual Report, 1978.

3. Arizona Survey.

4. Arkansas Survey.

5. California Survey.
5.(a) Evaluation of Teenage Pregnancy and Parenting (TAPP) program. Family Service Agency of San Francisco, et al, 1984.
5.(b) Position Paper on Adolescent Pregnancy, California Department of Health Services.
5.(c) Description of California State Assembly Bill 1069, "The Freedom of Choice Act," California Department of Health Services.

6. Colorado Survey.
6.(a) Teen Pregnancy/Parenting Services Guide (DRAFT). Colorado Department of Social Services.
6.(b) "Interventions for Pregnant Teens to Foster Self-Sufficiency." Colorado Department of Social Services.

7. Connecticut Survey.
7.(a) Report of the Legislative Task Force to Prevent Adolescent Pregnancy, Connecticut State Legislature, January, 1985.
7.(b) "Selected Characteristics of Connecticut Residents--Live Births, 1950-1983," Hugh Fritch, Maternal and Child Health Section, Connecticut State Department of Health Services, September, 1983.
7.(c) "Teenage Fertility Rate--Connecticut Residents--Years 1955, 1960, 1965-1983," Hugh Fritch, Maternal and Child Health Section, Connecticut State Department of Health Services, April, 1979 (revised 1980, 1981, 1982, 1983).
7.(d) Memorandum, from High Fritch, Maternal and Child Health Section, Connecticut State Department of Health Services, on the correlation between maternal age and low birthweight, February 7, 1985.
7.(e) Connecticut Resident Infant Deaths of 1982, by maternal age. (Source: Connecticut infant death/live birth certificate computer files of 1982).

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10.(a) "A Healthier Generation of Georgians," Georgia Department of Human Resources, January, 1985. Health study focusing on child and youth development, teenage pregnancy, child abuse and neglect, and emotionally disturbed children.

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13.(a) "The Parents Too Soon Program in Illinois" (description).
13.(b) "Past Administrative Efforts to Address the Problem," description of programs before "Parents Too Soon" was developed in 1983.
13.(c) Pamphlets on "Parents Too Soon."

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14.(a) "Problem Statement" in answer to Question 17 ("Do you see the prevention and assistance services in your State as adequate.."), on the need for early intervention with teen mothers to prevent child abuse, and on the need for centralized data collection and coordination for development of prevention programs.
14. (b) "Outcome Objectives," on the aims of a training program in parenting skills for adolescent parents.

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19.(b) "Family Services Program, Year One Report," Maine Department of Human Services, Bureau of Social Services, January 25, 1985.
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19.(f) "Summary Statistics on Adolescent Live Births" in Maine.

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20.(e) "Average Monthly Number" for participation and funding of AFDC in the state of Maryland, 1978, 1980, 1982, 1984 (chart).

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23.(b) "Model Programs in Minnesota" (chart), with programs and contact people.

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23.(d) "Directory of Family Planning and Related Services" in Minnesota, 1983.

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24.(a) List of Members of the Adolescent Pregnancy Task Force of the State of Mississippi.

24.(b) "Description of State Infant Mortality Programs," Mississippi.

24.(c) "Program Narrative: Mississippi State Department of Public Welfare, Proposal, Project Forward, To Reduce Adolescent Pregnancy," Mississippi Department of Public Welfare, November, 1984.

24.(d) Memorandum on the status of Project Forward, from Christine Ross, Coordinator of Project Forward in Region III, to Jane Wilson, Service Program Manager in Region III, July, 1985.

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28.(a) Memorandum on prenatal care, from the Medicaid Administrator, Nevada State Welfare Division, to Physicians, Clinics, and Hospitals, November, 1983.

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29.(b) "Creation and Collaboration on a Prevention Continuum: A School Based Model." Description of school-based programs for prevention of alcohol and drug abuse, Office of Alcohol and Drug Abuse Prevention, 1984.

29.(c) "Primary Prevention in High Risk Adolescents As An Adolescent Family Life Demonstration Prevention Project." Application for funding submitted to Office of Adolescent Pregnancy Programs, Federal Department of Health and Human

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29.(d) "Adolescent Health Clinic Grant Proposal Outline." Synopsis of grant proposal for demonstration project of school-based adolescent health clinic, Visiting Nurse Association of New Hampshire.

29.(e) Memorandum on services to adolescents through the State Division of Mental Health and Developmental Services, from Ellen Sheridan, Director of Public Education in New Hampshire, October 15, 1985.

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29.(g) "Budget Information" on the Teenage Pregnancy and Teenage Parent Program of the Visiting Nurse Association (chart).

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30.(b) Pamphlets from the Essex County Network on Adolescent Pregnancy (ECNAP), 1985.

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31.(a) New Futures School for Teen Parents, of Albuquerque, "Annual Statistics, 1983-1984".

31.(b) Follow-up data on students who attended New Futures School during the 1982-1983 school year, June, 1984.

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32.(a) Cover Letter on the Governor's initiative on teen pregnancy, from Joseph Cocozza, Executive Director of the New York State Council on Children and Families, April, 1985.

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32.(d) "Setting Directions: Initial Report of the New York Governor's Task Force on Adolescent Pregnancy," February, 1985.

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33.(a) "Statistical Report on Medical Care: Recipients, Payments, and Services," 1978, 1980, 1982, 1983-84, North Carolina Human Resources/ Medical Assistance Agency (charts).
33.(c) Consent form for Birth Control Pill, Family Planning Branch, Division of Health Services, Department of Human Resources.
33.(d) "Progress Report on a Workplan for Family Involvement Activities." Memorandum from Margie Rose, Head of the Family Planning Branch of the North Carolina Division of Health Services, to Rubye Parker, DHHS Region IV, January 5, 1984.

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34.(a) "Management Services--Research and Statistics--Federal Program Expenditures for Services to Adolescents--Medicaid, Title XX/ SSBG, AFDC, Adoption Assistance," North Dakota Department of Human Services.
34.(b) "Sex Education Provider Study--Final Report," North Dakota Council on Problem Pregnancy, February, 1983.

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36.(a) Oklahoma Public Health Code, legislation regarding adolescents' right of self-consent for health services under certain conditions.
36.(b) "Oklahoma Adolescent Health Programs," program list and description of the TEAM Program of the Moore Public Schools, the Teenage Postnatal Education Project, the Deaconness Home for adolescent mothers, Planned Parenthood educational programs, and the Salvation Army Maternity Home of Oklahoma.
36.(c) Pamphlets on specific, privately-run services for pregnant and parenting teenagers in Oklahoma.
36.(d) "Adoption in Oklahoma: A Study of Adoptive Families, Birthparents, Agencies, Legal Practices and Trends," Oklahoma Institute for Child Advocacy, November, 1984.
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37.(b) "Improving Services to Pregnant Teenagers and Teen Parents--1985-86 Budget and Policy Brief," from Pennsylvania.

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39.(a) "Adolescent Reproductive Health Education: Long-Term Retention of Sex Education Information by High School Students" in South Carolina, Lucinda L. Thomas, et al. With tables.
39.(b) Description of the Teen Pregnancy Reduction Network of South Carolina.
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41.(e) "Births, Infant Deaths, Fetal Deaths, Induced Abortions, and Deaths by Cause, With Rates, By Race, For the State and for the Counties--Resident Data, Tennessee, 1981" (chart).
41.(f) News Report and Description of State Senator Douglas Henry's Committee on Adolescent Pregnancy, including, "Facts About Teenage Pregnancy in Tennessee," 1984.
41.(g) Pamphlets on Parenting and Adoption, Tennessee Department of Human Services, 1984.

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42.(a) "Final Report on Adolescent Pregnancy and Teen Parents," Texas Health and Human Services Coordinating Council, October 3, 1985.
42.(b) "Task Force on Indigent Health Care: Final Report," Texas State legislature, December, 1984.
42.(c) "Texas Health and Human Services Coordinating Council Membership," list.
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44.(d) "Bennington Teenage Pregnancy Project," Kristin Williams Propp, M.A., Teen Pregnancy Counselor, February 12, 1985.

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45.(a) "1981 Vital Statistics Annual Report," Center for Health Statistics, Virginia Department of Health.

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46.(a) "Adolescent Pregnancy Demonstration Projects" in Washington State, March, 1985.

46.(b) "You and Your Baby: A Parenting Program for Parents of Babies from Birth to Six Months--Teacher's Guide," Maternal and Child Health Program, Washington State Department of Social and Health Services.

46.(c) Abstract on Washington State Teen POWER Project, a peer support and outreach program for adolescent mothers.

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47.(c) Description of the Youth Health Service of West Virginia.

47.(d) Members of the West Virginia State Task Force on Parental Notification (list).

47.(e) Memorandum on the new West Virginia State code on abortions to unemancipated minors, from L. Clark Hansbarger, State Director of Health, to All Providers of Abortion Services to Unemancipated Minors, May 24, 1984.

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APPENDIX IV

FEDERAL PROGRAM DESCRIPTIONS*

ADOLESCENT FAMILY LIFE PROGRAM

Legislative Authority

Title XX, Public Health Service Act; expired at the end of FY 1985. It is currently operating under a continuing resolution.

Administering Agency

Office of Adolescent Pregnancy Programs, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services; administered at local level by program grantees.

Program Description

This program awards grants to public agencies and private nonprofit organizations for projects to prevent adolescent pregnancy and assist pregnant adolescents and adolescent parents. Two types of services may be offered by grantees: (1) care services, for which only pregnant adolescents and adolescent parents are eligible; and (2) prevention services, which are services to prevent adolescent sexual relations and are available to any adolescent.

Care services may include services such as adoption counseling, referrals to pediatric care and maternity homes, educational and vocational services, child care, homemaking education, and family planning services. Prevention services include educational services to teenagers and their families intended to prevent or delay sexual relations, and pregnancy testing, nutritional counseling, and transportation (but no family planning services).

Under the law, grantees are to give primary emphasis to servicing adolescents under age 18. The federal share of funded projects is 70% in the first two years, with a decreasing federal share thereafter. (For a list of projects funded under AFLA, see Appendix V).

The adolescent family life program also funds research projects into the causes and consequences of adolescent pregnancy and parenthood. These projects are 100 percent federally funded.

Funding (millions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
-0-	$10.0	$13.5	$14.9	$14.7

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* These descriptions are drawn from "Federal Programs Affecting Children," Select Committee on Children, Youth, and Families, January 1984. Information has been updated where necessary using materials from the Congressional Research Service.

ADOPTION ASSISTANCE

Legislative Authority

Title IV-E of the Social Security Act, as amended; permanently authorized.

Administering Agency

Administration for Children, Youth, and Families, Office of Human Development Services, U.S. Department of Health and Human Services; administered at State level by State child welfare agencies.

Program Description

This program provides matching funds to the States, at the Medicaid matching rate (54 percent, nationally), for payments to parents who adopt an AFDC- or SSI-eligible child with "special needs." A child with special needs is defined as a child who is free for adoption and who has a specific condition, such as ethnic background, age, membership in a sibling group, or mental or physical handicap, which prevents him or her from being placed without assistance payments. The amount of the payments is to be based on the economic circumstances of the adoption parents and the needs of the child, but cannot exceed the amount the child was receiving as a foster child. Payments can continue until the child reaches the age of 18, or in some cases 21.

This program was established in 1980. All States participated in the program beginning in FY 1983.

Funding (millions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$5.0	$5.0	$5.0	$21.8	$32.3

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Legislative Authority

Title IV-A of the Social Security Act, as amended; permanently authorized.

Administering Agency

Office of Family Assistance, Social Security Administration, U.S. Department of Health and Human Services; administered at local level by county welfare offices.

Program Description

The Aid to Families With Dependent Children program was established by the Social Security Act of 1935 as a cash grant program to enable States to aid needy children without fathers.

The AFDC program provides cash payments to needy children (and their caretakers) who lack support because at least one parent is dead, disabled, continually absent from the home, or unemployed (in some States). All States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands offer AFDC for one-parent families; 23 jurisdictions also offer AFDC for two-parent failies under the AFDC-Unemployed Parent program.

States determine standards of financial need and, based on these standards, maximum benefit levels; Federal law governs the treatment of recipients' earnings. Since October 1, 1981, Federal law has imposed a gross income limit, set at 150 percent of the State's need standard. States set resource limits within the Federal outer limit of $1,000 in equity value per family in counted resources. Excluded are a home, the equity value of a car up to $1,500 (or a lower State limit); and, at State option, items of personal property deemed essential to daily iving.

Federal matching for AFDC benefits varies among States. All States except one receive AFDC reimbursement on the basis of the Medicaid formula , which offers cost-sharing for all benefits paid, no matter how high.

AFDC eligibility ends upon a child's 18th birthday unless a State chooses to pay benefits to high school students until they turn 19.

As a condition of eligibility, AFDC mothers must assign their child support rights to the State and cooperate with welfare offices in establishing paternity of a child born outside of marriage and in obtaining child support payments. The Deficit Reduction Act of 1984, however, required the first $50 per month of child support collected on the family's behalf be given to the family and not counted in determining the benefit amount for any family applying for or receiving AFDC.

Generally, able-bodied recipients are required to register for work or job training unless they are caring for a child under age 6.

AFDC elibibility confers automatic eligibility for Medicaid.

Additional changes to AFDC were made under authorization of the Deficit Reduction Act of 1984. The absolute income ceiling for those qualifying for AFDC was raised to 185% of the state's standard of need. The Act also extended the $30 work incentive disregard to 12 months, expanding the work incentive. Finally, the income of minor siblings and grandparents must be counted in determining a family's eligibility for AFDC and its benefit level.

Funding (billions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$6.8	$6.6	$6.8	$7.7	$8.0

(Spending for children and adults. The percentage of funds that goes to children is not available. Administrative costs are additional.)

EDUCATION CONSOLIDATION AND IMPROVEMENT ACT (ECIA)

Legislative Authority

Chapter 1, Education Consolidation and Improvement Act of 1981 (Title V, subtitle D of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35); expires at the end of FY 1987.

Administering Agency

Office of Elementary and Secondary Education, U.S. Department of Education; State and local education agencies.

Program Description

Two major types of programs are authorized under chapter 1 of the Education Consolidation and Improvement Act (ECIA): local education agency (LEA) programs and State agency programs. Most program funds are distributed under the LEA programs, wherein compensatory education services are provided to educationally disadvantaged children attending local public and private schools. Funds are distributed to and within LEAs based primarily on the number of children from poverty families. However, within schools selected for program participation, the eligibility of children for chapter 1 services is determined solely on the basis of educational disadvantage, not income.

The Department of Education (ED) has estimated that 75 percent of chapter 1 LEA grants are used for basic instructional services--the remainder for related services, administration, and minor construction. Approximately 78 percent of LEA program participants receive compensatory reading instruction, while 46 percent receive supplementary mathematics instruction.

The State agency programs provide funds to State agencies directly responsible for certain types of disadvantaged children: handicapped, migratory, and neglected or delinquent children. As with the LEA grant program, funds are used for compensatory education and related services for these specific groups of disadvantaged children served by State agencies.

Finally, chapter 1 also authorizes much smaller programs of grants for State administration (1 percent of the State's chapter 1 grant, or a minimum of $225,000), plus evaluation and studies of the effectiveness of chapter 1 activities.

Funding (billions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$3.1	$3.0	$3.2	$3.5	$ 3.7

FAMILY PLANNING

Legislative Authority

Title X, Public Health Services Act, expired at the end of FY 1985. It is currently operating under a continuing resolution.

Administering Agency

Office of the Assistant Secretary of Health, Public Health Service, U.S. Department of Health and Human Services; local family planning clinics.

Program Description

Title X provides support for (1) family planning clinics, (2) training of family planning personnel, and (3) development and dissemination of family planning and population growth information to all persons desiring such information. Most title X dollars are awarded to family planning clinics. Participating clinics must offer a broad range of family planning methods and services, including natural family planning methods, infertility services, and services for adolescents.

Grants and contracts are available to public or non-profit private entities to establish and operate family planning clinics. The Office of Family Planning allocates funds to the regional Department of Health and Human Services office which then determines which family planning projects should be funded. No matching requirements exist for these grants. However, Federal regulations specify that no family planning clinic project grant may be made for an amount equal to 100 percent of the estimated costs.

There is no statutorily mandated target population under title X, although regulations require that priority in the provision of clinic services be given to persons from low-income families. Clinics must provide services free of charge to low-income persons, who are defined by Federal regulation as persons whose income does not exceed 100% of the poverty level.

Funding (millions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$161.7	$124.2	$124.1	$140.0	$142.5

(Spending for children and adults. The percentage of funds that goes to women under 20 is not available.)

FOOD STAMP PROGRAM

Legislative Authority

Food Stamp Act of 1977 as amended; expired at the end of FY 1985. It is currently operating under a continuing resolution.

Administering Agency

Food and Nutrition Service, U.S. Department of Agriculture; administered at the State and local level by welfare departments.

Program Description

The food stamp program provides a monthly supplement in the form of food stamps to the food purchasing power of low-income individuals and families. Food stamp benefits received are usable to purchase food for home consumption, and in certain cases, prepared meals or food-related items such as seeds and plants for growing food at home. Assistance is provided directly to eligible low-income recipients through local welfare agencies and averages (in FY 1983) about $43 per person per month, although varying by income and household size. Benefit costs and roughly half of the program's administrative costs are financed by the Federal Government, with the remaining costs (half of State and local administrative expenses) financed by States and localities.

The program's eligibility and benefit rules are federally established and, with few exceptions, are nationally uniform. Eligibility depends on a household's income and liquid assets, although adult household members aged 18 through 59 must register for, seek, and accept suitable employment unless disabled, already employed, or caring for a disabled or very young dependent. Generally, the program aims at assisting households with gross monthly incomes below 130 percent of the Federal poverty level, and few categorical rules, such as disability status or age, are applied.

Beginning in FY 1982, the food stamp program in Puerto Rico was replaced by a nutritional assistance block grant that grants benefits in cash.

Funding (billions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$113.0	$11.2	$12.8	$12.6	$12.6

(Spending for children and adults. The percentage of funds that goes to children is not available. For fiscal years 1982 through 1985, includes funding for a nutritional assistance block grant to Puerto Rico.)

JOB TRAINING PARTNERSHIP ACT (JTPA)

Legislative Authority

Job Training Partnership Act; permanently authorized.

Administering Agency

Employment and Training Administration, U.S. Department of Labor; State Governors; local service delivery areas.

Program Description

The Job Training Partnership Act (JTPA) authorizes a number of Federal job training programs, including: (1) training for disadvantaged youth and adults to be administered through local service delivery areas; (2) summer youth employment and training, also administered by local service delivery areas; and (3) the Job Corps, administered directly by the Labor Department through national contractors. Services for youth include classroom training, on-the-job training, work experience, education, and a limited amount of subsidized employment, all during the academic year, and a summer youth employment program. Eligibility generally is limited to economically disadvantaged* 16 through 21 year olds, although 14 and 15 year olds can also be served at local option. The program is 100 percent federally financed, and local planning is conducted by Private Industry Councils, which represent local businesses and other interests, in partnership with local governments.

The Job Corps is a residential education and training program for educationally and economically disadvantaged youth aged 14 through 21.

The Job Training Partnership Act went into effect on October 1, 1983, replacing the Comprehensive Employment and Training Act (CETA). Job Corps and the summer youth employment program both had been authorized previously under CETA. However, in addition to the main training program for adults and youth, which existed under CETA and was replaced by JTPA, CETA had also authorized an additional separate program of youth training. Under JTPA, local areas receive a single grant for serving youth and adults, of which 40 percent must be used for youth.

Funding (millions)

CETA	FY 1981	FY 1982	FY 1983
Title II-B,C--training for adults and youth	$2,102	$1,152	$1,759
Title IV-A--youth training	825	192	192
Job Corps	561	586	618
Summer youth program	839	460	825
TOTAL	$4,327	$2,390	$3,394

JTPA	FY 1984	FY 1985
Title II-A	$1,886	$1,886
Job Corps	599	617
Summer youth program	825	725
TOTAL	$3,310	$3,228

(Amounts for title II under both CETA and JTPA, include spending for children and adults. The percentage of title II funds that went to children is not available. The total amount listed for JTPA only refers to programs relating directly to youth.)

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* Economically disadvantaged is defined as having income below 100 percent of the OMB poverty level or 70 percent of the Bureau of Labor Statistics lower living standard.

MATERNAL AND CHILD HEALTH (MCH) SERVICES BLOCK GRANT

Legislative Authority

Title V, Social Security Act; permanently authorized.

Administering Agency

Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services; State health agencies.

Program Description

The MCH Block Grant provides health services to mothers and children, particularly those with low income or limited access to health services. The purposes of the block grant include, among others, reducing infant mortality, reducing the incidence of preventable disease and handicapping conditions among children, and increasing the availablity of prenatal, delivery, and postpartum care to low-income mothers.

States determine the services to be provided under the block grant. Services can include prenatal care, well-child clinics, immunizations, vision and hearing screening, dental care, and family planning. They may also include in-patient services for crippled children, screening for lead-based poisoning, or counseling services for parents of Sudden Infant Death Syndrome victims.

By law, between 85 and 90 percent of the MCH block grant appropriation is allotted to states to provide health services under the block grant. Between 10 and 15 percent is reserved under a Federal set-aside. In FY 1983, 85 percent of the block grant appropriation was allotted among States. Each State's individual allotment is based on the proportion of total funding it received in FY 1981 under certain categorical programs now consolidated under the block grant program. These programs were MCH and crippled children's services, supplemental security income services for disabled children, lead-based paint poisoning prevention, sudden infant death syndrome, and adolescent pregnancy.

Eligibility criteria under the block grant may be set by the States themselves. States are allowed to charge for services provided; however, mothers and children whose incomes fall below the poverty level may not be charged for service.

Each year, 10 to 15% of the block appropriation is reserved under the federal set-aside for MCH special projects of regional and national significance, research and training, and genetic disease and hemophilia programs.

For each $4 in federal funds a state receives, it must spend $3 in state funds.

Funding (millions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$454.4	$373.0	$478.0	$399.0	$478.0

MEDICAID

Legislative Authority

Title XIX of the Social Security Act, as amended; permanently authorized.

Administering Agency

Health Care Financing Administration, U.S. Department of Health and Human Services.

Program Description

Medicaid is a Federal-State matching program providing medical assistance for certain low-income persons who are aged, blind, disabled, or members of families with dependent children. Within Federal guidelines each State designs and administers its own program. As a result, substantial variation exists among the States in terms of persons covered, services offered, and amount of payment for such services.

Medicaid authorizes medical vendor payments for covered services. Under the Medicaid program, States must provide minimum benefits for "categorically needy" individuals. In general, these are persons receiving assistance under the AFDC or SSI programs. Minimum benefits include inpatient and outpatient hospital services; laboratory and x-ray services; skilled nursing facility (SNF) services for those over age 21; home health services for those entitled to such care; early and periodic screening, diagnosis, and treatment (EPSDT) for those under 21 (see below); family planning services and supplies; and physician services. States may also cover "medically needy" persons, that is individuals whose incomes are slightly in excess of the standards for cash assistance, provided that (1) they are aged, blind, disabled, or members of families with dependent children, and (2) their income (after deductions for incurred medical expenses) falls below the State standard. States which choose to serve the medically needy may provide the same services to this population group as they do to the categorically needy but are not required to do so. However, States which do provide any services to the medically needy, must, at a minimum, provide ambulatory services for children and prenatal and delivery services for pregnant women.

The Defict Reduction Act of 1984 required states, as of October 1, 1984, to extend Medicaid coverage to certain categories of pregnant women and children whose coverage was previously provided at the State's option. This provision is known as the Child Health Assurance Program (CHAP). These categories include persons meeting AFDC income and resources requirements if they are (1) first-time pregnant women eligible from the time of medical verification of pregnancy; (2) pregnant women in two-parent families where the principal breadwinner is unemployed from the point of the medical verification of pregnancy; and (3) children born on or after Oct. 1, 1983, up to age 5, in two-parent families.

The Federal Government's share of Medicaid is tied to a formula which is inversely related to the per capita income of the State; the Federal matching rate thus ranges from 50 to 78 percent, with a national average of 54 percent. Administrative costs are generally matched at 50 percent except for certain items which are subject to a higher matching rate.

EPSDT is designed to increase the availability and quality of health care to children in low-income families. Under this program, States are required to provide or purchase the care and services necessary to screen, diagnose, or treat individuals under the age of 21 who are members of families designated as "categorically needy" by the Medicaid program. States must also develop an outreach program to inform eligible residents that such services are available. Eligibility for the program is based on Medicaid eligibility criteria. Reimbursement under the program is also under the general Medicaid reimbursement structure.

Funding (billions)

FY 1981	FY 1982	FY 1983	FY 1984
$3.5	$3.6	$3.5	$4.0

(Total Medicaid payments for child health services.)

SOCIAL SERVICES BLOCK GRANT (SSBG)

Legislative Authority

Title XX of the Social Security Act; permanently authorized.

Administering Agency

Office of Human Development Services, U.S. Department of Health and Human Services, State social service agencies.

Program Description

Under the social services block grant, States receive Federal funds to provide various social services to their citizens; funds are distributed to States according to their relative population. Within broad Federal guidelines, States are free to design their own programs, establish their own income eligibility criteria, and develop their own funding priorities. Prior to FY 1982, States were required to furnish non-Federal matching funds and to observe federally established income criteria and priorities for certain population groups, such as welfare recipients. Day care provided to children, which traditionally has been the single largest service funded title XX, also had to meet certain Federal requirements prior to FY 1982. However, the Omnibus Budget Reconciliation Act of 1981 eliminated most Federal regulation of the title XX program and transferred maximum decision-making authority to the States.

In FY 1982, services provided by most States included child day care, protective and emergency services for children and adults, counseling, family planning, home-based services such as homemaker and chore services, information and referral, and adoption and foster care services.

In FY 1985, there was an additional appropriation of $25 million under the SSBG for the training of child care personnel and parents in child development and child abuse prevention.

Funding (billions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$3.0	$2.4	$2.7	$2.7	$2.7

(Combined funding for title XX services and training. These figures represent total Federal funding for social services to adults and children. No breakdown is available on the percentage of these total appropriations which were used to benefit children. However, the Department of Health and Human Services estimates that in FY 1980, 39 percent of total title XX expenditures were for services provided exclusively to children and youth.)

SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

Legislative Authority

Child Nutrition Act of 1966, as amended; expired at the end of FY 1984. It is currently operating under a continuing resolution.

Administering Agency

Food and Nutrition Service, U.S. Department of Agriculture, State health departments and recognized Indian groups; local health agencies.

Program Description

The special supplemental food program for women, infants and children (WIC) distributes Federal funds to States and certain recognized Indian tribes or groups to provide supplemental foods to low-income, postpartum, and nursing mothers, and infants and children up to age 5 who are diagnosed as being at nutritional risk. The program operates out of local health agencies or community agencies providing access to health care. Funds are used to pay the cost of specified nutritional foods provided to WIC participants; to assist in meeting administrative costs associated with program operation; and to provide participants with nutrition education.

Food benefits provided under the program are provided monthly and consist of specified items which vary in type and quantity according to the nutritional needs of the participants. These consist largely of dairy products, cereals, fruit and vegetable juices and infant formula. Participants either receive the food from the local agency, or purchase it from a retail outlet through the use of a voucher issued by the local agency. This voucher specifies the items and quantities which may be purchased by the participant, and is the most common form of food delivery in the WIC program. Participants must show evidence of nutritional deficiency and have an income that is no higher than 185 percent of the poverty level in order to be eligible for the program. States may set income criteria that are lower than 185 percent of the poverty level; however, such criteria may not be set at less than 100 percent of this level. In FY 1982, the nationwide average monthly food benefit provided to a participant was $29.25.

Funding (millions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$887.6	$904.7	$1,360	$1,400	$1,500

(Spending for children and adults. The percentage of funds that goes to children is not available.)

VOCATIONAL EDUCATION

Legislative Authority

Vocational Education Act of 1963 as amended; expired at the end of Fiscal Year 1984. Replaced by the Carl D. Perkins Vocational Education Act of 1984.

Administering Agency

Office of Vocational and Adult Education, U.S. Department of Education; the State board of vocational education and the State vocational education advisory council; local education agencies and area vocational education schools.

Program Description

On October 19, 1984, the Carl D. Perkins Vocational Education Act was signed into law. This new law is a comprehensive revision and replacement of the Vocational Education Act of 1963 (VEA), and represents the first major modification of the program since 1976.

Ninety-seven percent of funds authorized under this Act are designated for basic State grants, with two percent reserved for national programs. Bilingual vocational training funds are distributed as project grants by the Secretary of Education.

From its basic State grant, each State must spend, according to its State plan, 43 percent for vocational education program improvement, innovation, and expansion. The other 57 percent must be spent for vocational education programs for special populations and activities. Funds must be reserved for disadvantaged (either economically or academically) and handicapped persons. Each State may reserve up to 7 percent of its total allotment from all grants for administrative expenses.

A number of new activities are authorized, including programs for: native Hawaiians, severely disadvantaged youth served by community-based organizations, industry-education partnerships for training in high-technology occupations, a national assessment of vocational education conducted by the National Institute of Education, cooperative demonstration education programs, State equipment pools, and demonstation centers for the retraining of dislocated workers.

Funding (millions)

FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
$685.6	$659.5	$732.3	$742.0	$842.0

(Spending for children and adults. The percentage of funds that goes to children is not available.)

APPENDIX V

ADOLESCENT FAMILY LIFE PROGRAM GRANTEES BY STATE - 1985

Grantee	No.	Amount Awarded	Project Director
ALABAMA			
Charles Henderson Child Health Center P.O. Box 928 Troy, AL 36081	701	$226,622	John A. Little 205-566-7600
ARIZONA			
Tucson Unified School District No. 1 1010 East Tenth St. Tucson, AZ 85717	511	$160,370	Sherry Betts 602-628-7881
CALIFORNIA			
Family Service Agency of San Francisco 1010 Gough St. San Francisco, CA 94109	101	$264,290	Amy Williams 415-648-8810
COLORADO			
Child Opportunity Program, Inc. 3607 Martin Luther King Blvd. Denver, CO 80205	516	$184,286	Marilyn Spurlock 303-399-0603
CONNECTICUT			
Eastern Connecticut Parent-Child Res. System 158 Main St. Putnam, CT 06260	508	$93,479	Richard T. Cass 203-928-6567
Hill Health Corp. 400 Columbus Ave. New Haven, CT 06519	515	$20,000	Carlos Salguero, M.D. 203-436-7810
DISTRICT OF COLUMBIA			
Gallaudet College 800 Florida Ave., N.E. Washington, DC 20002	301	$43,430	Margaret G. Hallau 202-651-5039
Cities-In-Schools, Inc. 1325 W Street, N.W. Washington, DC 20009	703	$340,000	Maurice Weir 202-328-1216
COSSMHO - The National Coalition of Hispanic Mental Health & Human Services Orgs. 1030 15th Street, N.W. Washington, DC 20005	802	$353,464	Jane L. Delgado 202-371-2100
National Conference of Catholic Charities 1346 Connecticut Ave., N.W. Washington, DC 20036	811	$315,783	Rosemary Winder 202-785-2757
DISTRICT OF COLUMBIA (Cont'd)			
American Red Cross 17th Street, N.W. Washington, DC 20006	814	$174,960	Bruce Spitz 202-639-3016

FLORIDA Economic Opportunity 5361 N.W. 22nd Ave. Miami, FL 33142	505	$38,146	Pearl Garrick 305-635-7701
YWCA of St. Petersburg 647 First Ave., North St. Petersburg, FL 33701	509	$67,500	Peggy Sanchez 813-896-4629
GEORGIA Parent and Child Development Services 312 East 39th St. Savannah, GA 31401	107	$85,714	Brenda Nelson 912-355-8577
Emory University School of Medicine Atlanta, GA 30322	312	$81,435	Marion Howard, Ph.D. 404-588-4204
GUAM Dept. of Public Health & Social Services P.O. Box 2816 Agana, Guam 96910	109	$113,318	Karen Cruz 617-734-4192
HAWAII State of Hawaii, Dept. of Health 761A Sunset Ave., Wilcox Bldg. Honolulu, HI 96816	507	$96,900	Henry Ichiho, M.D. 808-735-3056
IDAHO Community Health Clinic, Inc. 1503 Third St., North Nampa, ID 83651	117	$156,030	David Reese 208-467-4431
ILLINOIS University of Illinois 1207 West Oregon Urbana, IL 61801	118	$92,032	Edmund V. Mech 217-333-2261
Hull House Assn. 118 North Clinton Chicago, IL 60606	504	$180,543	Marrice Coverson 312-726-1526
Committee on the Status of Women 1850 E. Ridgewood Lane Glenview, IL 60025	816	$101,901	Kathleen Sullivan 312-729-5042
INDIANA Lutheran Family Services of N.W. Indiana 8127 Merrillville Road Merrillville, IN 46410	317	$82,964	Joel Ambeling 219-769-3521
City of Gary 1100 Massachusetts Ave. Gary, IN 46407	510	$12,833	Barbara Farrar 219-886-3051
KANSAS Lyon County Health Dept. 802 Mechanic Emporia, KS 66801	517	$60,603	Eileen Greischar, R.N. 316-342-4864

KENTUCKY

Lexington-Fayette County Health Dept. 650 Newtown Pike Lexington, KY 40508	503	$115,883	Carol Bryant, Ph.D. 606-252-2371

LOUISIANA

Louisiana Dept. of Health & Human Resources P.O. Box 94095 Baton Rouge, LA 70804-9095	102	$57,608	Angelin Morgan 504-342-2715
Dept. of Health and Human Resources 1525 Fairfield Ave. Shreveport, LA 71130	308	$62,260	Sandy Cahn 318-226-7480
Family of the Americas Foundation 1150 Lovers Lane, P.O. Box 219 Mandeville, LA 70448	804	$229,576	Gail Cox 504-626-7724

MAINE

Genesis Program 200 College Street Lewiston, ME	115	$214,840	Mavourneen Thompson 207-783-1021
Medical Care Development, Inc. 11 Parkwood Drive Augusta, ME 04330	313	$101,544	Patricia Randolph 207-622-7565

MARYLAND

St. Ann's Infant & Maternity Home 4902 Eastern Ave. Hyattsville, MD 20782	105	$136,734	Sister Cora Anne Signaigo 301-559-5500

MASSACHUSETTS

Our Lady of Providence Children's Center 2112 Riverdale Street West Springfield, MA 01089-1099	119	$209,523	Allison Farrington 413-788-7366
St. Margaret's Hospital 90 Cushing Ave. Dorchester, MA 02125	711	$292,519	Frances L. Kellogg 617-436-8600

MICHIGAN

Wayne County Intermediate School District 2000 Pagel Lincoln Park, MI 48146	104	$100,000	Drema Raupp 313-386-1250
Catholic Social Service of Wayne County 9851 Hamilton Ave. Detroit, MI 48202	307	$41,334	Gail Zettel 313-883-2100

MINNESOTA

Minnesota Institute 2829 Verndale Ave. Anoka, MN 55303	309	$94,429	Richard Neuner 612-427-5310
St. Paul-Ramsey Medical Center Commission 640 Jackson St. Paul, MN 55108	702	$210,000	Laura Edwards, M.D. 612-221-8876
Search Institute 122 W. Franklin Ave., Suite 215 Minneapolis, MN 55404	801	$194,626	David Schuelke, Ph.D. 612-870-3664

MISSISSIPPI Exchange Club Parent/Child Center 2906 N. State Street, Suite 401 Jackson, MS 39216	114	$41,817	Becky Williams 601-366-0025
MISSOURI S.E. Missouri Assn. of Public Health Administrators 515 First Street, P.O. Box 805 Kennett, MO 63857	705	$47,598	Beth Welborn-Bischof 314-888-5892
MONTANA Young Families Program, Inc. 903 North 30 Street Billings, MT 59101	112	$62,414	Michele Konzen 406-259-2007
Montana State University 221 Herrick Hall Bozeman, MT 59717	315	$84,388	Joye B. Kohl 406-994-3241
NEBRASKA Father Flanagan's Boys Home 2606 Hamilton Street Omaha, NB 68131	110	$112,072	Mary Fran Flood 402-341-1333
NEW HAMPSHIRE Visiting Nurse Assn. 194 Concord St. Manchester, NH 03104	103	$64,235	Sarah Hubbard 603-622-3781
NEW JERSEY Camden County Dept. of Health 1800 Pavilion West, 2101 Ferry Ave. Camden, NJ 08104	522	$290,531	Ruth Salmon, Ph.D. 609-757-4458
NEW MEXICO La Clinica de Familia, Inc. 101 North Alameda Blvd. Las Cruces, NM 88005	108	$85,106	Shirley Dundon 505-523-2042
NEW YORK Mt. Vernon Public Schools 165 N. Columbus Ave. Mount Vernon, NY 10553	302	$116,486	Marcia Miller 914-668-6580
Manpower Demonstration Research Corp. 3 Park Ave. New York, NY 10016	803	$180,000	Barbara B. Blum 212-532-3200
National Urban League, Inc. 500 East 62nd St. New York, NY 10021	805	$193,574	Johanne C. Dixon 212-310-9238
Covenant House 460 W. 41st St. New York, NY 10036	807	$409,029	Catherine Ashman 212-613-0363
Southern Tier Office of Social Ministry 160 High St. Elmira, NY 14901	808	$275,000	Anthony T. Barbaro 607-734-9784
Bank Street College of Education 610 West 112th St. New York, NY 10025	810	$273,000	Jacqueline L. Rosen 212-663-7200
Boys Clubs of America 771 First Ave. New York, NY 10017	815	$162,081	Roxanne Spillett 212-557-8597

NORTH CAROLINA			
Greene County Health Care P.O. Box 657 Snow Hill, NC 28580	501	$90,287	Helen Hill 919-747-5841
OKLAHOMA			
Salvation Army Maternity Home 7802 W. 7th St. Tulsa, OK 74101	116	$136,430	Mrs. Jacqueline Tolan 918-245-1827
Margaret Hudson Program P.O. Drawer 6340, 1205 W. Newton Tulsa, OK 74148	314	$66,920	Nancy Pate 918-585-8163
OREGON			
Young Women's Christian Assn. 768 State St. Salem, OR 97301	111	$3,174	Pat Casey 503-581-9922
PENNSYLVANIA			
The Guidance Center 620 W. Main St. Smethport, PA 16701	316	$71,987	Carol Mikanowicz 814-887-5591
Maternal & Family Health Services 37 N. River St. Wilkes Barre, PA 18701	512	$114,500	Francis Angelella 717-822-2325
PUERTO RICO			
Caguas Regional Hospital Dept. of Health P.O. Box 5729 Caguas, PR 00626	113	$163,756	Francisco Ramos, M.D. 809-743-4406
RHODE ISLAND			
Rhode Island Dept. of Human Services 600 New London Ave. Cranston, RI 02920	121	$150,000	Francine Connolly 401-464-3415
Providence Ambulatory Health Care Foundation 469 Angell St. Providence, RI 02906	706	$131,000	Lynne Spector 401-861-6300
SOUTH CAROLINA			
Florence Crittenton Home and Hospital 19 St. Margaret St. Charleston, SC 29403	120	$172,593	Mary Green 803-722-7526
University of South Carolina School of Public Health Columbia, SC 29208	303	$66,961	Murray Vincent, Ed.D. 803-777-5152
St. Mary Human Development Center Route 1, Box 177 Ridgeland, SC 29936	519	$161,904	Ellen Robertson, Ph.D. 803-726-3338
SOUTH DAKOTA			
South Dakota Dept. of Health 523 East Capitol Pierre, SD 57501	318	$98,540	Karen E. Pearson 605-773-3737

TENNESSEE			
Douglas Cherokee Economic Authority P.O. Box 1218 Morristown, TN 37814	513	$131,406	Cynthia P. Norton 615-587-4500
TEXAS			
Catholic Family Service 1522 S. Van Buren Amarillo, TX 79101	514	$203,875	Larry Watson 806-376-4571
University of Texas Health Science Center 5323 Harry Hines Blvd. Dallas, TX 75235	809	$470,700	Robert G. McGovern, M.D. 214-688-2948
UTAH			
Brigham Young University Dept. of Family Services Provo, Utah 84602	306	$133,123	Terrance D. Olson, Ph.D. 801-378-3375
University of Utah Medical Center 50 N. Medical Drive Salt Lake City, Utah	710	$144,167	Arthur Elster, M.D. 801-581-3729
Utah State University Developmental Center for Handicapped Person Logan, Utah 84322-6800	813	$148,467	Helen Mitchell 801-750-2000
VERMONT			
Addison County Parent/Child Center Box 646 Middlebury, VT 05753	521	$142,500	Susan Harding 802-388-3171
VIRGINIA			
Norfolk State University 2401 Corprew Ave. Norfolk, VA 23504	520	$91,473	Margaret J. Kelly, Ph.D. 804-623-8651
American Assoc. for Counseling & Development 5999 Stevenson Ave. Alexandria, VA 22304	812	$100,432	Sharon Alexander 703-823-9800
WASHINGTON			
Tacoma/Pierce County Health Dept. 3629 South D Street Tacoma, WA 98403	506	$111,172	Arlene Brines 206-593-4813
Adoption Services of WACAP P.O. Box 2009 Port Angeles, WA 98362	806	$291,250	Barbara Dunbar-Burke 206-943-3182
WISCONSIN			
Family Hospital 2711 Wells St. Milwaukee, WI 53208	502	$182,501	Mary Jo Baisch 414-937-2727
WEST VIRGINIA			
Memorial General Hospital Assn. 1200 Harrison Ave. Elkins, WV 26241	704	$188,500	Frances Jackson 304-636-9450

LEGEND:

100 Series = Care
300 Series = Prevention
500 Series = Combination
700 Series = Special Consideration
800 Series = National

ADDITIONAL VIEWS OF HON. GEORGE MILLER, CHAIRMAN; HON. WILLIAM LEHMAN; HON. PATRICIA SCHROEDER; HON. MATTHEW F. McHUGH; HON. TED WEISS; HON. BERYL ANTHONY, JR.; HON. BARBARA BOXER; HON. SANDER M. LEVIN; HON. BRUCE A. MORRISON; HON. J. ROY ROWLAND; HON. GERRY SIKORSKI; HON. ALAN WHEAT; HON. MATTHEW G. MARTINEZ; HON. LANE EVANS; HON. HAMILTON FISH, JR.; AND HON. NANCY L. JOHNSON

We find unacceptable a million, mostly unwanted, teen pregnancies each year; 500,000 births, more than half to unmarried teens; and, 400,000 abortions.

Not only is it unacceptable, but as this Committee has heard, it is devastating for the vast majority of the teen parents. They will earn less, they will complete fewer years of education, their infants will be at risk, and their early marriages will be more likely to end in divorce.

Such devastation is not necessary. Other countries do much better. And there are currently examples throughout this country of programs that can reduce both the incidence of unwanted pregnancy, and the ensuing consequences. So we know that the private pain and public cost of teen pregnancy need not be inevitable.

The choice is now up to policymakers, at every level. We can expand opportunities for adolescents to participate more fully in society, including the opportunity to gain better control over their own lives by having the necessary information and services to make responsible choices about parenting. And we can give parents of these adolescents the help they are seeking.

Or we can continue to condemn and ignore this national tragedy, allowing it to take its toll on young people and the nation.

This is not to suggest that it is easy to deal with the problems of adolescence, especially those involving sexual activity. As we were told at one of our early hearings:

> Because we give adolescents almost no opportunities for acknowledged competence beyond academics and athletics, and because we fail to invite the contributions they are ready to make to their communities, many adolescents are barred from adult recognition. In so doing, we abandon them to the peer group which, while more often than not supportive and generous, is equally shaky and needy (15).

It is within this often confused, and relatively immature context, that the problem of teen pregnancy must be understood. For many of the teens involved, poverty is also a daily fact of life, and is a further constraint on their opportunities.

That is why we feel so strongly about reaching young people with adequate prevention and intervention efforts. They need, by their age and circumstance, our best and most honest guidance regarding questions of sexual behavior, pregnancy and parenthood.

We believe we can do better by focusing much more on preventing unwanted teen pregnancies. Those who are concerned about the issue of adolescent pregnancy and parenthood agree that preventing teenage pregnancy is a priority.

We know contraception works. We know sex education can make a real contribution. We know comprehensive health care is essential. And we know there are emerging prevention models, like school-based clinics, that have already shown enormous potential.

This Report makes all too clear that these proven and promising preventive approaches are everywhere too few, under-emphasized, and uncoordinated.

We can be certain what will happen if we continue along this path.

We will see hundreds of thousands more teen parents each year, looking at a future of almost certain poverty.

We will see their infants, from the outset, at much greater risk of mortality and morbidity. We will watch these families struggle to overcome great odds. We will see their children perform less well than others in school, increasing the likelihood that they too will drop out of school, beginning a repeat of the same high-risk cycle.

In addition to the private tragedy of teen pregnancy, this Report confirms the astounding costs of teen pregnancy. Literally tens-of-billions of public and private dollars are spent each year caring for the basic needs of these infants, and their parents.

PERSISTENCE AND MAGNITUDE OF TEEN PREGNANCY CAUSES PARENTS TO SEEK HELP

During the 1970s, millions more teenagers became sexually active, and at younger ages. In the 1980s, this increase has slowed and may even be reversing (9). The pregnancy rate among teens has followed a similar pattern -- with an increase in the 1970s, and considerable slowing of the increase since 1980 (5).

We are heartened that these trends may be turning around.

But the fact remains that too many teenagers become pregnant or bear children when they are not ready or able to shoulder the emotional, physical, or fiscal responsibilities of being parents. In 1982 (the most recent year for which comparable information is available), 1,110,287 young women through age 19 became pregnant, and 523,531 gave birth (1). Of those who gave birth, 51% were unmarried (8).

These persistent trends have greatly affected public attitudes regarding adolescent behavior and parents' roles.

As evidenced in a recent Lou Harris poll, many more parents are now talking with their children about sex, but the topic of birth control is not often included in those conversations.

Parents admit they need help now, and overwhelmingly support sex education in schools. They believe eliminating such education would lead to more teen pregnancies. Also, a two-to-one majority of adults favor public schools linking up with family planning clinics, so that teens can learn about contraceptives and obtain them (10).

CONTRACEPTION IS EFFECTIVE PREVENTION

While contraception alone cannot solve the problem of teenage pregnancy, contraception has had a significant impact on averting unwanted pregnancies and births.

According to one study, absent the use of contraceptives, in 1976 there would have been 680,000 additional pregnancies among unmarried sexually active 15-19 year olds. A separate analysis showed that enrollment by teens in family planning clinics averted 119,000 births and an estimated 331,000 pregnancies in 1976. Combining these two findings, it appears that family planning programs were responsible for half of the averted unintended pregnancies in 1976 (14).

We also know that, contrary to what many believe, teens can be effective contraceptive users. In other countries where the rate of sexual activity is as high as in the United States, the teen pregnancy rate is significantly lower. In the Netherlands, Sweden, France, Canada, and England and Wales, contraceptive services and sex education are more readily available and teens use contraceptives consistently and effectively (6). Even in the United States in 1982, teenagers aged 15-19 had the highest annual visitation rate to all sources of family planning services (private, clinics, and counselors) than all other age groups (9).

The evidence shows plainly, though, that teens are likely to become pregnant during the first six months of sexual activity -- the time period when they are delaying contraceptive use. The fact is that too many teens do not use a contraceptive at first intercourse (more than 75% of teens under age 15; 59% of 15-17 year olds; and 45% of 18-19 year olds), and delay seeking contraception for six months to two years, depending on their age. (2).

Studies have found that teenagers delay seeking contraception for the following reasons: 1) belief that time of month was low risk; 2) their youth; 3) infrequent sex; 4) general belief they could not get pregnant; 5) and difficulty in obtaining contraceptives (2).

Thus, while contraception can be effective, it is too frequently unavailable or unused when sexual activity begins.

SEX EDUCATION CAN HELP REDUCE TEEN PREGNANCY

We realize that sex education remains a controversial topic. Many have questioned whether schools are a proper place for sex education. Others have questioned the effectiveness of such efforts in influencing rates of sexual activity, contraceptive use, and pregnancy and birth rates.

We believe, however, that many types of sex education can contribute to reducing teen pregnancy. Studies show that sex education leads neither to higher levels of teenage pregnancy nor to greater sexual activity (7). In fact, a 1982 study found that teenagers who received sex education were more likely to use some method of birth control. One study combining data from 1976 and 1979 found a lower pregnancy rate among females who had received sexuality education than among those who had not (7).

Another recent study, which examined the association between sex education and adolescent sexual behavior, showed that 15-16 year old adolescents who had taken a course in sex education were less likely to be sexually experienced. This study also showed that parental roles are supplemented, not undermined, by sex education programs (4).

MORE FAMILY PLANNING SOUGHT BY STATES

The family planning program is the major source of prevention services to adolescents. An estimated 34% of those served are women under the age of 20.

Although controversial to some, according to our survey, states view family planning as very effective. Several states noted that this program assists in the provision of services to teens and encourages greater family involvement. Ten states recommended increasing the availability and accessibility of family planning services.

SCHOOL-BASED EDUCATION/CLINIC SERVICES ARE EVEN MORE EFFECTIVE

Recent research, using more sophisticated methodology, has also shown that when education is combined with clinic services at an accessible location, teen pregnancy is reduced.

In this research study, nine different prevention programs were evaluated and compared for relative effectiveness 1/. While most programs increased knowledge among teens, no program significantly increased or decreased rates of sexual intercourse. None of the non-clinic programs had a significant impact upon reported use of

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1/Programs selected: 1) A comprehensive, semester-long course for juniors and seniors; 2) A one-year course for juniors and a semester seminar for seniors; 3) A one-year freshman course and a semester course and a semester-long junior/senior seminar; 4) An integrated K-12 program; 5) A five session course in schools, including a parent/child program; 6) A six-session course in schools, including a peer education program; 7)A 10-16 session course for youth groups; 8) An all-day conference; 9) A high school education/clinic program.

different methods of birth control. Only the education/clinic approach increased the use of birth control and substantially reduced the number of births. It also increased the proportion of pregnant adolescents who remained in school, and decreased the number of repeat pregnancies among them (7).

This study was based upon the comprehensive high school-based clinic program in St. Paul, Minnesota, which the Select Committee visited in 1983, and corroborates the earlier information given to the Committee showing a 56% reduction in the fertility rate. Since our visit the program has been expanded and has shown consistent results.

Another particularly noteworthy education/clinic program begun in 1981 in two Baltimore schools reduced pregnancy rates among sexually active adolescent females, while overall teenage pregnancy rates in Baltimore were on the rise. Services provided included sexuality edcuation, counseling, and referral for contraceptives (11).

Mounting evidence suggests that low self-esteem and poor prospects for the future, including too few academic or employment opportunities, may contribute to a teenager's decision to have a child (3, 12, 13).

School-based clinics, by providing a range of services to adolescents, can detect other health, academic, social and family problems that may contribute to low self-esteem and lowered prospects for future self-sufficiency. For example, during the first three months of operation, seventy-five percent of the visits to DuSable High Schools's clinic were unrelated to family planning. They revealed previously undetected health and emotional problems that were amenable to treatment (17). Similar information has emerged from clinics in Dallas, Kansas City and St. Paul.

In St. Paul, more than 60% of the clinic visits were for services unrelated to family planning or pregnancy, including child abuse, mental health problems, financial problems, and weight control. Treatment of minor and acute illness, and preventive health care accounted for more than one-third of all the visits (16).

Part of the success of comprehensive school based clinics is due to their broad base of support in the community. Each program draws together parents and students, schools and health agencies, churches and social service providers, and governmental and private resources. And each program organizes its services to fit the environment, facilities, and concerns of the teenagers it is designed to serve.

Fifteen States in our survey reported programs providing school-based health services. Seven States already have or are planning to start school-based health clinic programs that offer health services to the entire student population.

Following are just two examples of States' recommendations on this approach:

> Connecticut
>
> School-based health clinics are a demonstrated means of providing comprehensive medical, educational, and counseling services. These clinics provide total medical services to students, not just services related to the prevention of pregnancies and pre- and post-natal care. In terms of the adolescent pregnancy problem, the goals of such clinics are the prevention of adolescent pregnancies, reduction of second pregnancies, reduction of obstetrical complications, and improvement of the health of the infant and mother.

In Connecticut, three clinics similar to the St. Paul model are now operating, although not on a full-time basis. They are located in New Haven, Bridgeport and Hartford. The task force recommends expanding these programs from half-time to full-time operations. It also recommends that the state, through the Department of Health Services, provide two planning and development grants for the establishment of one new urban school clinic and one new rural school clinic.

Maryland

The Governor "direct the Department of Health and Mental Hygiene and the Maryland State Board of Education to develop a joint plan for a network of comprehensive school-based health programs and that the Governor include funding for such programs in high-risk areas in the Fiscal Year 1987 budget. The plan should include a profile by which those middle and senior high schools with significant teen pregnancy problems could be identified and placed in priority order."

OTHER COMPREHENSIVE SERVICES ALSO REDUCE TEEN BIRTH RATES

At earlier Select Committee hearings and site visits, we have seen other prevention strategies which have reduced teen birth rates. For example:

-- The Young Adult Clinic at the Columbia Presbyterian Medical Center in Washington Heights, New York, offers: health services and contraceptive counseling to adolescent 21 and younger; outreach to schools and community organizations to reach pre-teens before they bbbecome sexually active; parent sex education seminars and conferences; a bilingual improvisational theater troupe to increase parent-teen communication; and a community health advocate program staffed by community residents.

These efforts decreased the percent of teens who were pregnant before their first clinic visit from 44% to 34%, and decreased the percentage of births to teens in that community from 13.8% in 1976 to 11.9% in 1983.

-- The Teen Health Project at the Ryan Community Health Center in New York City provides: routine health care and health maintenance, immunizations, job and sports physicals, complete contraceptive care, education and counseling, WIC and social service referrals, outreach to schools and youth programs, and referrals to job development and substance abuse programs.

As a result, since 1976, the rate of teen pregnancies in their community has declined 13.5%.

SOME STATES BEGIN TO EMPHASIZE PREVENTION

Effective prevention includes a variety of approaches. Sex education, family life education, abstinence education, family planning, teen counseling services, general health services for adolescents, school dropout prevention programs, parent education programs, and mass media campaigns are all accepted and important preventive measures.

Eleven States specified that there has been too little focus on prevention (Georgia, Illinois, Maryland, Michigan, New Jersey, New York, North Carolina, North Dakota, Texas, Washington, and Wyoming). Many others also called for increasing services for adolescents before a first pregnancy occurs.

Illinois has made a major commitment to adolescent pregnancy prevention, and appropriated $12 million for its model statewide initiative, "Parents Too Soon", begun in 1983.

As part of its statewide initiative, the New York Governor's Task Force on Adolescent Pregnancy pointed out the inadequate focus on prevention which has historically characterized service delivery to teens.

North Carolina acknowledged the same problem, noting "too little is being provided too late for primary prevention."

CONCLUSION

It is not enough to lament the problem of unwanted teen pregnancy and parenting, or to chastise its victims.

Everyone regrets the number of unwanted pregnancies and births to teens, the abortions, and the lack of services to those who become teen parents and their infants.

Everyone agrees that, for the majority of these teens and their children, life will be much more difficult than it is for others.

What is important is to start building on the base of knowledge that we have about our teenage population, and on the information we have about coping with a wide range of problems that affect teens in America.

This effort must begin by seriously dealing with what may be the single most devastating event in a young adolescent's life -- an unwanted teenage pregnancy.

To take seriously our responsibilities as parents, providers and policymakers, we have an obligation to provide better, more consistent, and more honest guidance and opportunities for teens than we have.

We believe that this Report provides more than enough evidence to suggest that very great progress can be made. Some states and communities have begun to take up the challenge. The state and local innovations identified in this report should serve as models in this important effort.

They cannot do it alone. Without a greater effort on our part, the crisis-oriented, uncoordinated, and piecemeal efforts which states have described to us as totally inadequate, will continue.

It is our hope that this Report will galvanize a more concentrated commitment to America's adolescents from both public and private talent and resources.

George Miller, Chairman
William Lehman
Patricia Schroeder
Matthew F. McHugh
Ted Weiss
Beryl Anthony, Jr.
Barbara Boxer
Sander M. Levin
Bruce A. Morrison
J. Roy Rowland
Gerry Sikorski
Alan Wheat
Matthew G. Martinez
Lane Evans

Hamilton Fish, Jr.
Nancy L. Johnson

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ADDITIONAL VIEWS OF HON. NANCY L. JOHNSON AND HON. HAMILTON FISH, JR.

Preventing adolescent pregnancy is an issue which is central to any comprehensive federal policy to assist American families, American women, and an indeterminate number of future generations. It is an issue that is clearly within the purview of the Select Committee on Children, Youth, and Families to provide leadership, and we are pleased that the Committee has begun to address this serious problem.

For women, who have made great strides in the past two decades in expanding their horizons to include a range of abilities, the implications of teen pregnancy are devastating. Only half of the girls who became mothers before their 18th birthday received their high school diplomas; 70% of women on the public assistance rolls did not complete their high school education; and, an equal percentage of welfare recipients under 30 had their first child as a teenager.

These numbers make a mockery of efforts to address the feminization of poverty. Strategies which have only recently begun to direct girls into higher-paying, nontraditional fields will be lost on a generation of mothers who, lacking an education, may become dependent on public assistance for long periods of time. Far too many young women are narrowing their options in their teen years.

Particularly disheartening, and noteworthy as indicating the urgency of the problem, are the health risks of pregnancy to young mothers and children. Poor nutrition and inadequate medical attention, conditions which too often characterize these

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pregnancies, in turn makes the risk of low birthweight and infant mortality significantly higher for the child of a teenage parent.

Teen pregnancy today even has negative implications for tomorrow's retirees. In 1950, the wages of 17 workers contributed to the benefits of each Social Security beneficiary. By the year 2000, the checks will reflect the contribution of only three workers. With this dramatic shift in the ratio of retirees to workers, we can't afford to ignore that the quality of life for future seniors depends to a great extent on the job readiness of today's children. How can we expect that either the mothers or their children will be equipped to shoulder this responsibility?

Existing programs, especially preventive strategies such as Title X of the Public Health Services Act and the Social Services Block Grant, both successful in assisting adolescents, are appropriately cited in this report, together with state assessments.

We are disappointed, however, that the report has been limited to a compilation of existing efforts and has not provided the thorough examination and guidance that should be the role of a Congressional Oversight Committee and is so urgently required for a problem of this magnitude.

We are concerned that countless hours of staff time and enormous amounts of paper have been directed, at taxpayers' expense, to a directory which duplicates information gathering in a number of governmental entities, including the National Association of State Legislators, the National Governor's Association, and our own State agencies, all of which have published similar documents.

We believe that the number of teenage pregnancies, one million and rising, and the rate of abortions, higher than any industrialized nation, demonstrate that these approaches are inadequate; they cry for an immediate and creative response, and we would like to see this report, not as the final statement on the problem, but as the first of several examinations of possible courses of action.

Finally, we are dismayed by the lack of participation in the study accorded to Committee Members. Members were allowed to comment on survey questions and pursuant to Committee rules, provided with an opportunity to express an opinion in the final three day comment period prior to the publication of this document. However, Members' individual views were not solicited when the decision was made to conduct a survey, a decision which had direct impact on the final outcome.

Despite the importance of the subject, and the best and most thorough efforts of the Select Committee's staff, we cannot, in good conscience, appear to be wholeheartedly behind this report. In our view the report does not reflect the work of Committee Members from beginning to end, nor does it seek to determine the root causes, the consequences, and possible new solutions to this critical problem of such individual and collective importance.

Squarely facing the challenge presented by an overabundance of adolescent pregnancies is crucial to creating the opportunity this nation has always symbolized and to preserving the quality of life for current and future generations. As Members of the Select Committee for Children, Youth, and Families we wish to express our concern and commitment to solutions for this problem, and our expectation that future efforts will more clearly identify causes and stimulate the spectrum of new aproaches that must be found if our policies are to make a difference.

Nancy L. Johnson
Hamilton Fish, Jr.

MINORITY VIEWS OF HON. DAN COATS, RANKING MINORITY MEMBER; HON. THOMAS J. BLILEY, JR.; HON. DAN BURTON; HON. BARBARA F. VUCANOVICH; HON. DAVID S. MONSON; AND HON. ROBERT C. SMITH

INTRODUCTION

We are very pleased that the Select Committee is focusing its attention on adolescent pregnancy. The increasing incidence of pregnancies among young, unmarried teens is one of the most difficult and far-reaching social problems our nation faces. It is a major factor affecting increases in poverty, unemployment, infant mortality, abortion, child abuse, juvenile delinquency and a host of other tragic ills of our day.

This report will be useful to those working at all levels to address the causes and consequences of teen pregnancy. Especially useful are the State Fact Sheets, the heart of this report. From these Fact Sheets, we can learn of the variety of programs and initiatives springing up in our 50 States. States have much to learn from each other and will prove each others' best teachers. We hope that this report will prove a valuable resource through which successful programs can be discovered and duplicated, and mistakes avoided.

However, much as we are pleased with the strengths of the report and the genuine cooperative spirit shown by the Majority during its development and writing, there exist fundamental disagreements which prevent us from giving the report our endorsement. These involve matters which were discussed when the survey was first drawn up and throughout the process of revising the report as first drafted by the Majority.

The most important part of this issue is the prevention of pregnancies among unmarried teens. Without minimizing the importance of appropriate services to pregnant and parenting teens, we still must recognize that an effective means of prevention would be preferred by all. No government effort, no matter how well-designed and well-funded, will compensate children for their absent fathers.

A strong case can be made that pregnancy prevention policies we have pursued so far have been ineffective. *Births* to teens have been reduced through abortion. Pregnancies to *all* teens have declined slightly in recent years. But *pregnancies* to *unmarried* teens have risen higher than we would have thought possible 15 years ago.

The design of this report does not lend itself to treatment of this most important issue. Discussion of prevention programs centers on availability, access, and funding, but never touches upon the prior question of effectiveness. There is little point in discussing how to increase the availability of prevention programs when we don't even know if those programs work.

We very much appreciate the hard work of the Select Committee staff and the Majority's sincere efforts to address our concerns in this report. But just as the Majority has found itself unable to bend on certain points which it considers fundamental to understanding this problem, so have we. Adolescent pregnancy is a matter which is important enough to deserve continued and open-minded debate. We hope that this report signals the beginning of that debate, and not the end.

I. DEFINING THE PROBLEM

The Select Committee report suffers from a lack of clear definition of the problem of teen pregnancy. This is due in part to the difficulty of obtaining some data, but in part also to a fundamental disagreement among Committee Members as to what the real problem is. In any case, this lack of definition manifests itself in a general failure to distinguish between married and unmarried teens and in a far greater emphasis on birth rates than on pregnancy rates.

We believe that the general public does indeed distinguish between the married and the unmarried in its concern for teen pregnancy. Nor is it concerned only with births to unmarried teens, but with pregnancies as well. Family planning providers are certainly sensitive to this latter difference; few would claim success if they lowered the numbers of births simply by increasing the numbers of abortions.

Pregnancies among unmarried teens--what the trends are and how to prevent them--this is the public's concern. This is our concern. But information on pregnancies to unmarried teens is difficult to obtain. Pregnancy figures generally are calculated by adding the figures for births, abortions, and miscarriages. Problems arise in attempting to distinguish between pregnancies to married and unmarried women. Birth certificates give the marital status of the mother, but abortion information does not. Therefore, surveys which must rely upon self-reporting are a major source for pregnancy estimates. But self-reporting of abortions is usually thought to be low. And it is more likely that abortions performed before 1973 are underreported.

Recognizing these difficulties, the fact remains that the information which is most difficult to obtain is also that which would best answer our questions. If we want to learn about pregnancy rates for unmarried teens, data which does not distinguish between the married and unmarried can only bring us so far. Therefore, realizing that survey results give us estimates rather than statistics, we must move forward with what we have if we are to address the most critical concerns.

Teen Pregnancy Outcomes

Of all pregnancies to teens aged 15-19, slightly less than half result in live births, about 40% are aborted, and the remainder are lost through miscarriage. Of live births, about half are born to married teens, and a little more that half of those were conceived after marriage. (See Table 1.)

Differences Between Older and Younger Teens

In 1981, about 60% of all pregnancies to teens were to 18 and 19 year olds. The pregnancy rate for 18-19 year olds was about 225% greater than the rate for those 15-17, but the birth rate was about 255% greater. (See Table 2.) Older teens are less likely than younger teens to have pregnancies ended through abortion or miscarriage.

Mothers 18-19 have a lower percent of low-birth-weight babies than do those 15-17. (See Figure 3 of Committee Report.) Mothers 18-19 are also more likely to be married than those 15-17.

Differences Between Married and Unmarried Teens

Married teens tend to have healthier babies than unmarried teens. In fact, married 15-17 year olds have lower rates of low-birth-weight babies than unmarried women of any age. (See Figure 3 of Committee Report.) About half as many unmarried teens begin prenatal care in the first trimester of pregnancy than do those teens whose pregnancy was conceived after marriage. Of those who become pregnant outside of marriage, almost 80% more of those who marry before the birth begin early prenatal care than do those who remain unmarried. (See Table 3.)

Teens who are married at the birth of their babies have fewer low-birth-weight babies. Among teen mothers who began prenatal care in their first trimester, differences between married and unmarried teens with regard to fetal losses, low-birth-weight, and low 1-minute Apgar scores are marked. Unmarried teens were found to have more than twice the percent of low-birth-weight babies as married teens, regardless of whether the married teens' pregnancies were premaritally or postmaritally conceived. (See Table 4.)

Pregnancy Rates for Unmarried Teens

Births to teens have declined over the past 15 years, but the decline is due almost entirely to the increase in abortions. (See Figure 1, Committee Report.) Pregnancies to unmarried teens have soared. Studies by Zelnik and Kantner in 1971, 1976, and 1979, and by the National Survey of Family Growth in 1982 measured the percentage of pregnancies for never-married women aged 15-19 in those years. The results showed a near doubling of pregnancies from 1971 to 1979 (from 8.5% to 16.2%) and then a slight drop (to 13.5%) in 1982. More interesting, however, are the percentage of pregnancies among sexually active teens during this eleven year period. These have remained nearly constant, rising from 28.1% in 1971 to 32.5% in 1979, and then falling back to 30.0% in 1982. (See Table 5.)

The significance of these last figures is great. If the pregnancy rates among unmarried sexually active teens have remained constant over the past several years, then the chief factor in the increase of pregnancies among unmarried teens is the increase in the percentage of those who are sexually active.

The major thrust of almost all teen pregnancy prevention programs has been to decrease the percentage of sexually active teens who become pregnant. Very little effort has been made to prevent teens from becoming sexually active. Now, after nearly a decade and a half of this policy, it seems that there has been no change in the percentage of sexually active teens who become pregnant, but there has been a huge increase in the percentage of teens who are sexually active. (See Table 6.) And this increase in sexual activity has led to a proportionate increase in pregnancies to unmarried teens.

II. EXAMINING SOLUTIONS

Efforts to increase use of contraceptives among sexually active teens seem to have been successful. According to studies by Zelnik and Kantner, use of oral contraceptives (as the method most recently used) by sexually active unmarried teens doubled from 1971 to 1976 (23.8% to 47.3%) and declined slightly (to 40.6%) in 1979. Yet as stated in the lead editorial of the October, 1980 issue of Family Planning Perspectives, the dilemma persists that, "more teenagers are using contraceptives and using them more consistently than ever before. Yet the number and rate of premarital adolescent pregnancies continues to rise."

In recent years, various groups have come up with plans for addressing the problems of teen pregnancy anew. The solutions they have proposed seem to lead along two radically different paths. One leads back to the family and acknowledgement of parental responsibility while the other leads further from the family, towards schools as the provider of guidance.

Family Involvement

The "family path" led to the 1981 change in Title X which mandated increased efforts by Title X providers to involve parents in their children's decisions regarding sexual activity and contraceptive use. It was also responsible for the creation of the Adolescent Family Life Program, which emphasizes parental authority, family involvement, and the postponement of sexual activity for teens. Finally, it can be seen in various state and federal efforts to require parental consent or notification for minors receiving prescription contraceptives or abortions.

Responses to the Select Committee survey indicate that several states have taken the mandate for increased parental involvement to heart. They have initiated special programs for parents and teens in efforts to increase communication. In all, 13 states indicated that they had recently taken steps to encourage parental involvement in their programs.

Eight states indicated that they require parental notification or consent for minors to receive prescription contraceptives or abortions. Such requirements are generally supported by parents. In a September, 1985 survey conducted for Planned Parenthood Federation of America, 52% of parents with children aged 6-18 said that they favored "a federal law prohibiting family planning clinics from giving birth control assistance to teenagers unless they have received permission from their parents." Forty-four percent opposed such a law and 4% were not sure. Fifty-four percent of Blacks and 56% of Hispanics favored a parental consent law.

Family planning providers often criticize parental consent and notification requirements, contending that they will result in an increase in pregnancies and births to teens. However, a review of the data provided by those states reporting such requirements yielded no indication of significant increases in pregnancies, births, or abortions which might have resulted from the requirements. In Minnesota, a 1981 law requiring parental notification for abortions was followed by dramatic reductions in abortions, births, and pregnancies. From 1980 to 1983, abortions to teens aged 15-17 decreased 40%, births decreased 23.4%, and pregnancies decreased 32%. During this same period, the number of teens aged 15-19 decreased 13.5%. (See Minnesota State Fact Sheet.)

School-Based Programs

The other path to pregnancy prevention leads through the schools. Its strengths include comprehensiveness, confidentiality, and easy access. School based health clinics have received much publicity in recent months, largely because of the success of the oldest and best known of these projects, in St. Paul, Minnesota, but also because of the protests of parents in some new school sites. Members of Congress have already introduced legislation for federal grants to start up new school-based projects.

The success of the St. Paul program seems remarkable from the statistics often quoted. Births to teens in the participating schools declined from 59 per thousand high school girls in 1976-77 school year to 21 per thousand in 1979-80, but then increased again to 37 per thousand in 1984-85. Because the program does not collect its data in the same way as does the city of St. Paul or the state of Minnesota, comparisons are difficult. But the greatest difficulty with the numbers from the St. Paul program is that they reflect births to teens, not pregnancies. Pregnancy rates for the schools are not available.

More interesting is the fact that the decline in births reversed itself during the same school year that Minnesota passed its law requiring parental notification for abortions. As was noted above, enactment of the law was followed by statewide decreases in pregnancies, births, and abortions among younger teens. But as these declined for the state as a whole, birthrates increased in the St. Paul school-based program.

School-based health clinics seem to lead in a direction quite opposite to that of family-oriented programs. Descriptions by those who promote the clinics call into question those qualities most touted as chief strengths.

"Comprehensiveness" serves a double purpose--

Most school-based clinics began by offering comprehensive health care, then added family planning services later, at least partly in order to avoid local controversy. The early St. Paul experience demonstrated that a clinic limited to providing family planning services, pregnancy testing, prenatal and post-partum care, and testing and treatment for STDs (sexually transmitted diseases) will be unacceptable even to many of the students who want these services.

"School-Based Health Clinics: A New Approach
To Preventing Adolescent Pregnancy?"
Joy Dryfoos
Family Planning Perspectives, Vol. 17, No. 2,
March/April 1985, p. 71.

High rates of childbearing among students often are cited as the rationale for initiating on-site health clinics, yet school-based clinics generally are presented as comprehensive, multiservice units that emphasize physical examinations and treatment of minor illnesses. This portrait certainly is valid, considering that only a small proportion of all clinic visits are for family planning. Nevertheless, in most clinics new patients (whether male or female) are asked at their initial visit if they are sexually active. If they are or plan to be soon, they are encouraged to practice contraception.

"School Based Health Clinics," p. 72.

"Confidentiality" takes on the color of sneaking--

Clinic personnel stress the importance of maintaining confidentiality. One difficulty is that while students' privacy must be respected, it is also important to gain the acceptance of parents, so that parents will permit their children to be treated in the school clinic. School-based clinics generally require parental consent before they will provide medical services to teenagers. In some clinics, parents are asked to sign a blanket consent form unrelated to any specific clinic visit. In others, the form lists each service, including family planning, and a student may receive only the services that have been checked. Most consent procedures apply for the entire period of the student's enrollment.

"School-Based Health Clinics," p. 73.

The relative effectiveness of the school-based clinics is clearly related to the ease with which the young people can be followed up without endangering

> the confidentiality of the relationship. (That is, it is often difficult to follow adolescent clinic patients who have not informed their parents about their participation; but in the school program, the young people can be reached without communications to the home.)
>
> "Adolescent Pregnancy Prevention Services In High School Clinics"
> Laura E. Edwards, Mary E. Steiman, Kathleen A. Arnold and Erick Y. Hakanson.
> Family Planning Perspectives, Vol.12, No. 1, January/February 1980, p. 12.

"Easy access" seems to refer more to the clinician's access to the child than the child's access to the clinician--

> Almost all follow-up can be undertaken in school clinics, as family planning patients can be contacted easily in their classes and scheduled for follow-up visits. Confidentiality still can be maintained, because classmates do not know why the student is being asked to come to the clinic. Nevertheless, follow-up is perceived as a major challenge; one administrator hopes to reward students who make regular return visits with points toward school trips or other perquisites. In another program, students who miss a monthly follow-up visit receive a telephone call at home from the school nurse, requesting simply that they return to the clinic for a checkup.
>
> "School-Based Health Clinics," p. 73.

> School-based programs help to link health education and clinic services. Clinic staff often conduct sex education and family life classes in the school, so they have ample opportunity to encourage the students in the classroom to attend the clinic. One school has a room designated for health education, where contraceptives such as diaphragms and condoms are displayed; there are also counseling offices where students can talk to health educators in private. In that school, all sexually active students receive counseling, including a psychosocial evaluation.
>
> "School-Based Health Clinics," p. 73.

> Additionally, the nurse clinician keeps a log of all students on contraception and contacts them at least once a month in the school to discuss any problems related to contraceptive use. Some students have literally been seen on almost a daily basis, dropping by between classes, for example,

> to report to the nurse clinician, "I took my pill today, Mary."
>
> "Establishing an Experimental Ob-Gyn Clinic In A High School"
> Laura E. Edwards, Mary E. Steinman, and Erick Y. Hakanson
> American Public Health Association, Washington, D.C., November 2, 1977, p. 3.

And the creative mix of public and private funding does not seem destined to last--

> Although private funds have played an important part in starting up these programs, almost all of the school programs look to public support for continuation.
>
> "School-Based Health Clinics," p. 73.

> Although it is not fashionable to suggest that long-term viability depends on federal funding, it is difficult to imagine that foundations will be willing to support these programs permanently, except for special studies.
>
> "School Based Health Clinics," p. 73.

It should be noted, too, that the "comprehensiveness" of the school-based clinic often precludes a separate consent form for children whose parents do not wish contraceptives to be made available to them. If a parent wishes his child to receive the same free medical services that all other children receive at the clinic (emergency treatment, routine school and sports physical exams, immunizations, examination, diagnosis and treatment of complaints, etc.) the parent must sign a form which also includes family planning, treatment of sexually transmitted diseases, and professional counseling regarding sexuality. (See Exhibit A.)

Will "Family Planning" Work for Young, Single Teens?

Currently, federal policy mandates that children be given contraceptives without their parents knowledge and consent. The result has been a dramatic increase in the rate of pregnancy among unmarried teens, due to a proportionate increase in sexual activity among unmarried teens and no decrease in pregnancy rates for those who are sexually active.

Rather than acknowledge the failure of current efforts, some now offer a few adjustments to the unsuccessful programs:

1) Ensure better access--(If teens will not come to the clinics, take the clinics to them.)
2) Increase confidentiality--(Parents, it seems, are still the greatest hurdle to teaching children "responsible sex".)
3) Offer free comprehensive health care which includes contraceptive services--(Make parents an offer they can't refuse.)

Will the school-based approach work? Those who also predicted the success of Title X services to teens say that it will. But the real answer depends on whether contraception is or can be the final solution to teen pregnancy. The contraceptive failure rate for teens who always use contraception is about 10% (Zelnick and Kantner, 1976 and 1979). This is not much different from the out-of-wedlock teen pregnancy rate for the population as a whole. Therefore, hypothetically, if sexual activity among teens reached 100% and the constant use of contraceptives reached 100%, we would still have a pregnancy rate of about 10%.

CONCLUSION

The task we face today is not a new one. Every generation has inherited the difficult job of bringing children into adulthood, and the same problems have presented themselves.

What is so different now? Why does the problem seem so much more difficult in this generation? Are babies born today different from babies born fifty years ago? Or is the difference in the adults who are raising them?

Have we really failed in our efforts to prevent pregnancies to unmarried teens? Or is it truer to say that we have abandoned them? Teaching our children to be adults is perhaps the most difficult job we have. Teaching them self-control, respect for themselves and others, fidelity, courage, and patience requires constant and tireless efforts. It also requires good example.

Progressively over the past 25 years we have, as a nation, decided that it is easier to give children pills than to teach them respect for sex and marriage. Today we are seeing the results of that decision not only in increased pregnancy rates but in increased rates of drug abuse, venereal disease, suicide, and other forms of self-destructive behavior.

Our excuse for this decision is, "The kids are going to do it anyway; we ought at least to protect them from the worst consequences of their behavior." But this is perhaps the weakest argument of all.

It is true that without adult guidance in matters of sexuality, adolescents will tend toward promiscuity. Evidence of this can be found in the near doubling in the percentage of sexually active teens in the years since we have replaced real guidance with medical technology.

But even today it is clear that teen sex is not inevitable. About half of all 18-year old females have never had premarital intercourse. (See Table 6.) Of those unmarried teenage girls who were labeled "sexually active", almost one in seven had engaged in intercourse only once (Table 7), and about 40% had not had intercourse in the last month (Table 8). These are not the marks of an irreversible trend.

The time has come to stop blaming the problem of teen pregnancy on the incorrigibility of our children or the ills of society. Our children have only us for guidance, and we are responsible for the condition of our society.

The real path back to a sane and effective policy to prevent teen pregnancies is not an easy one, but it is the only one that will work. It is also the only one that most of us would choose for our own sons and daughters. This path does not circumvent the family, but leads straight to the heart of it. It encourages communication between parents and children and is built on the firm foundation of parents' values, beliefs, and ambitions for their children.

This Committee is uniquely priviledged to have the time and resources to examine the broad question of what form this new direction in teen pregnancy prevention might take. It is our sincere hope that the Committee will take up this challenge and begin the work of rebuilding our confidence in our families and our children.

Dan Coats, Ranking Minority Member
Thomas J. Bliley, Jr.
Dan Burton
Barbara F. Vucanovich
David S. Monson
Robert C. Smith

TABLE 1

Estimated Distribution of Pregnancies to Teens in 1982 by Outcome

OUTCOME	NUMBER	PERCENT
Total Pregnancies to teens 15-19	1,092,645	100.0
Abortions	432,850	39.6
Miscarriages	146,037	13.4
Live Births	513,758	47.0
Conceived Postmaritally	145,907	13.4
Conceived Premaritally, Born Postmaritally	118,678	10.9
Born Premaritally	249,173	22.8

Source: Table 1; O'Connell & Rogers, 1984, Table 1.

TABLE 2

Estimated Number of Pregnancies and Pregnancy Rates by Outcome of Pregnancy, Age of Woman, and Race: United States, 1976, 1978, and 1981

AGE OF WOMEN	1976				1978			
	ALL PREGNANCIES	LIVE BIRTHS	INDUCED ABORTIONS	FETAL DEATHS	ALL PREGNANCIES	LIVE BIRTHS	INDUCED ABORTIONS	FETAL DEATHS
	NUMBERS IN THOUSANDS							
Under 15 Yrs.	32	12	16	4	29	11	15	4
15-19 Years	1,073	559	363	151	1,109	543	419	147
15-17 Years	NA	NA	NA	NA	438	203	169	66
18-19 Years	NA	NA	NA	NA	671	341	250	81

AGE OF WOMEN	1981			
	ALL PREGNANCIES	LIVE BIRTHS	INDUCED ABORTIONS	FETAL DEATHS
	NUMBERS IN THOUSANDS			
Under 15 Yrs.	28	10	15	3
15-19 Years	1,103	527	433	142
15-17 Years	425	187	176	61
18-19 Years	678	340	257	81

RATE PER 1,000 WOMEN

AGE OF WOMEN	1976				1978			
	ALL PREGNANCIES	LIVE BIRTHS	INDUCED ABORTIONS	FETAL DEATHS	ALL PREGNANCIES	LIVE BIRTHS	INDUCED ABORTIONS	FETAL DEATHS
Under 15 Yrs.	3.2	1.2	1.6	0.4	3.2	1.2	1.6	0.4
15-19 Years	101.4	52.8	34.3	14.3	105.1	51.5	39.7	13.9
15-17 Years	NA	NA	NA	NA	69.7	32.2	26.9	10.5
18-19 Years	NA	NA	NA	NA	157.2	79.8	58.4	19.0

AGE OF WOMEN	1981			
	ALL PREGNANCIES	LIVE BIRTHS	INDUCED ABORTIONS	FETAL DEATHS
Under 15 Yrs.	3.1	1.1	1.7	0.4
15-19 Years	110.3	52.7	43.3	14.2
15-17 Years	72.7	32.1	30.1	10.5
18-19 Years	163.1	81.7	61.9	19.4

Source: Ventura, S.J., Taffel, S. and Mosher, W.D., "Estimates of Pregnancies and Pregnancy Rates for the United States", 1976-1981, Public Health Reports, Jan-Feb 1985, Vol 100, No. 1, Table 1.

TABLE 3

Percentage of teenage mothers' having a first birth who began prenatal care in the first trimester, by marital status at conception and birth and race of child, United States, 1980.

RACE OF CHILD	TOTAL ALL* MARITAL STATUSES	PREMARITAL CONCEPTION		MARITAL CONCEPTION
		UNMARRIED AT BIRTH	MARRIED AT BIRTH	
All races**	35.7	24.1	43.2	52.8
White	38.2	21.3	44.1	52.8
Black	28.8	27.2	33.2***	48.9***

* For married mothers, includes only those married once, husband present

** Includes races other than white and black

*** Does not meet standards of statistical reliablility; that is, the relative standard error is 25 percent or more

Source: Ventura, S.J. & Hendershot, G.E., "Infant Health Consequences of Childbearing by Teenagers and Older Public Health Reports, March-April 1984, Vol. 99, No. 2, Table 6.

TABLE 4

Outcome of first births in terms of three infant health measures for mothers* under 20 years, according to marital status at conception and birth, and trimester of pregnancy prenatal care began, United States, 1980.

TRIMESTER PRENATAL CARE BEGAN AND INFANT HEALTH MEASURE	TOTAL ALL MARITAL STATUSES	UNMARRIED AT BIRTH	MARRIED AT BIRTH	MARITAL CONCEPTION
ALL MOTHERS				
Fetal losses per 1,000 births	5.2	5.6	3.8	5.9
Percent of infants weighing less than 2,500 gm	8.9	10.8	7.4	6.2
Percent of infants with 1-minute Apgar scores less than 7	10.4	11.1	10.1	9.2
FIRST TRIMESTER				
Fetal losses per 1,000 births	4.8	6.1	3.2	4.8
Percent of infants weighing less than 2,500 gm	8.3	13.4	6.1**	5.2**
Percent of infants with 1-minute Apgar scores less than 7	12.1	15.7	11.5**	9.1**

* For married mothers, includes only those married once husband present

** Does not meet standards of statistical reliability that is the relative standard error is 25% or more

Source: Ventura & Hendershot, 1984, Table 5.

TABLE 5

Percentage of Women Aged 15-19 Who Ever Were Pregnant Before Marriage, for all Women and Those Who Ever had Premarital Intercourse, by Race, 1971, 1976 and 1979.

Women aged 15-19	1971			1976			1979			1982		
	Total	White	Black	Total	White	Black	Total	White	Black	Total	White	Black
All												
%	8.5	5.6	25.3	13.0	10.0	26.5	16.2	13.5	30.0	13.5	10.6	28.2
(N)	(2,739)	(1,758)	(981)	(1,449)	(880)	(569)	(1,717)	(1,034)	(683)			
Had premarital intercourse												
%	28.1	21.4	47.2	30.0	26.1	40.1	32.5	29.0	45.4	30.0	24.4	52.4
(N)	(958)	(445)	(513)	(726)	(349)	(377)	(938)	(479)	(459)			

Source: Unpublished tabulations from the NSPG-III; Zelnik and Kantner, 1980: Table 3.

EXHIBIT A

DuSable Clinic
DuSable High School
Chicago Public Schools

CONSENT TO ENROLL MINOR IN DuSABLE CLINIC

NAME OF MINOR: ______________________________

ADDRESS: ______________________________

BIRTHDATE: ______________ PHONE #: ______________

I do hereby request, authorize, and consent to the enrollment of my son/daughter or minor for whom I am legal guardian in the DuSable Clinic.

I understand that all services are free, and that I will not be charged for any services my son/daughter receives in the Clinic.

I understand that my signing this consent allows the physicians and professional Clinic staff of the DuSable Clinic to provide the following comprehensive health services:

1. Emergency treatment
2. Routine school and sports physical exams
3. Immunizations
4. Appropriate laboratory tests
5. Examination, diagnosis, and treatment of complaints of pain or ill being identified by my child
6. On-going care of existing medical conditions
7. Treatment of sexually transmitted diseases
8. Pregnancy testing, prenatal and post partum examinations
9. Family planning, including pregnancy prevention
10. Professional counseling in regards to nutrition, personal hygiene, sexuality, substance abuse, family and relationship issues and other health related areas

For further information about the Clinic or any of its services, feel free to call ______________ or drop into the Clinic, Room ________ DuSable High School.

PARENTAL CONSENT FOR HEALTH SERVICES

I do hereby give my informed consent for my son/daughter ______________ to receive the services offered by the DuSable Health Clinic and to complete confidential questionnaires. Furthermore, I release the Chicago Board of Education and its members, officers, employees, agents and representatives from any and all claims, suits, actions, liabilities, legal costs, and attorneys' fees arising out of the operation of the DuSable Health Clinic.

______________________ Signature of Parent/Guardian

______________ Date

TABLE 6

Percentage of Never Married Women Aged 15-19 Who Ever Had Intercourse, by Race, U.S. 1971, 1976, 1979, 1982.

AGE	1971 - Zelnik-Kanter			1976 - Zelnik-Kantner			1979 - Zelnik-Kantner			1982-NSFG		
	TOTAL	White	Black	Total	White	Black	Total	White	Black	Total	White	Black
Total	27.6	23.2	52.4	39.2	33.6	64.3	46.0	42.3	64.8	42.2	40.3	52.9
15	14.4	11.3	31.2	18.6	13.8	38.9	22.5	18.3	41.4	17.8	17.3	23.2
16	20.9	17.0	44.4	28.9	23.7	55.1	37.8	35.4	50.4	28.1	26.9	36.3
17	26.1	20.2	58.9	42.9	36.1	71.0	48.5	44.1	73.3	41.0	39.5	46.7
18	39.7	35.6	60.2	51.4	46.0	76.2	56.9	52.6	76.3	52.7	48.6	75.7
19	46.4	40.7	78.3	59.5	53.6	83.9	69.0	64.9	88.5	61.7	59.3	78.0

Source: Unpublished Tabulations from the NSFG, Cycle III, 1982; Unpublished Tabulations from the National Longitudinal Survey of Youth, 1983; Zelnik and Kantner, 1980, Table 1.

TABLE 7

Percent of Sexually Experienced Never-Married Women Aged 15-19 Who Had Intercourse Only Once, by Age and Race, 1976.

AGE	RACE ALL	WHITE		BLACK	
		%	N	%	N
15-19	14.8	14.3	379	12.7	410
15-17	19.9	18.4	206	18.4	217
18-19	8.6	9.3	173	6.2	193

Source: Zelnik & Kanther, 1977, Table 2

TABLE 8

Distribution (in Percentages) of Intercourse in the 4 Weeks Preceding Interview Among Never Married Women Aged 15 to 19, by Race: 1971, 1976, and 1979.

Frequency of Intercourse*	1971			1976			1979		
	Total (n=777)	White (n=330)	Black (n=447)	Total (n=590)	White (n=247)	Black (n=343)	Total (n=809)	White (n=388)	Black (n=421)
0	38.3	36.9	41.7	47.5	45.7	51.8	41.8	40.2	46.8
1-2	31.3	30.6	32.3	22.2	19.7	28.0	24.6	23.9	26.7
3-5	17.7	17.5	18.1	15.0	15.9	13.0	14.1	13.3	16.5
6 or more	12.9	15.0	7.9	15.3	18.8	7.2	19.5	22.6	10.0
Mean	NA	NA	NA	2.9	3.4	1.7	3.7	4.1	2.3

*In the 1971 survey these precoded categories were used; in the 1976 and 1979 surveys individual responses were recorded.

NA: not available

Source: Zelnik, 1983, Table 2-7.